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President's Page

TEMPORARY VICTORY

The Eisenhower landslide is behind us now and well embedded in history. It is only reasonable to conjecture whether the average American, who spoke out so violently last month, now considers he has discharged his obligation to free enterprise and can safely rest on his laurels.

Many fear that this is precisely the state of mind which will develop, and those of us concerned with the medical frame of mind fear it particularly. Let us hope we are wise enough to have learned our lesson thoroughly in the last eight years. We cannot relax now and we probably cannot relax tomorrow. Rather, with a temporary victory in hand, now is the time to redouble our efforts in behalf of the American system of medical practice.

Consider the controversial bill H. R. 7800, now Public Law 590. Few Texas physicians realize the sweeping implications of this law on our statute books today. A word of reminder on the developments that brought it into being:

The law as written contained a section (sec. 3) that provided benefits for all the millions under social security who were totally or permanently disabled. The section was unobtrusively tucked into the broad general bill which allegedly strengthened the simple provisions of social security as an institution. Actually, the disability benefit section represented one of the main four points in national compulsory health insurance as originally submitted in the Wagner-Murray-Dingell bills of the past.

Medicine opposed it on these grounds as well as because of the fact that paying bounty for disability soon leads to paying bounty for illness, which is the last step before out-and-out socialized medicine.

The bill passed the House last fall in spite of medical opposition. In the Senate, the controversial section 3 was finally struck out. At that point doctors relaxed, having "won their victory." We forgot that

there always follows conference committee compromise when the two houses disagree.

This compromise was a document remarkable in its veiled wording. Stripped down it simply said, "We will put in the disability benefits but we won't enact them until Congress has time to hold hearings with all interested parties next year after election."

Drum beaters for socialized medicine feel that they have won a major victory, because they now have the intent of the section in the law. They need only cross the last hurdle of setting the law in motion on or before July 1, 1953 by getting past this enabling legislation.

We may be assured that that is precisely what will happen unless medicine makes itself felt at these hearings, probably this spring, and finally drives section 3 out of the bill. Texas doctors should do two things: we should obtain copies of Public Law 590 (AMA's Washington office can supply them) and we should understand the implications of that law. Then, we must make our views known immediately and intelligently to our Congressmen and our Senators.

Remember that as vital as is the defeat of this section itself, its major importance lies in the broader overall picture. That picture clearly shows that proponents of socialized medicine will be working harder than ever before.

Our November election was a temporary victory. We must not relax; we must redouble our efforts if we are to maintain the type of government that the American people have so forcefully demonstrated they want maintained.

T. C. Terrell

TEXAS STATE JOURNAL OF MEDICINE

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COUNTY SOCIETY OFFICERS TO CONFER

County medical society officers will receive major attention the week-end of January 17-18 in Austin. In addition to being guests for the semi-annual meeting of the Executive Council of the Texas Medical Association on Sunday, January 18, county officers are being urged to attend their own meeting from 2 until 5 p. m. Saturday, January 17. This meeting for county society officers is the second held under the sponsorship of the Committee on Public Relations in an effort to create better understanding among physicians of the problems which face the medical profession and the services which are available to them at the state and national levels. Both meetings will be in the Association's headquarters building.

Featured on a special panel session at the Saturday meeting will be Leo Brown, director of public relations for the American Medical Association, and Dr. Frank E. Wilson, director of the A.M.A.'s Washington office. Mr. Brown will discuss the services and facilities of the A.M.A. maintained for individual doctors and for county societies, and Dr. Wilson will report major trends in national legislation in 1953. Other speakers will be N. C. Forrester, executive secretary; Philip R. Overton, general attorney; and W. E. Syers, public relations counsel, covering different phases of the Texas Medical Association as they relate to county societies. Dr. T. C. Terrell, President of the Association, will preside, and Dr. Troy A. Shafer, chairman of the Committee on Public Relations, will act as moderator for the panel discussions. An informal question and answer period will permit presidents, secretaries, legislative chairmen, public relations chairmen, and other local officers to discuss their problems and make suggestions for the year's activity.

A factual handbook for presidents and secretaries and other materials for use in local public relations activities will be distributed.

An informal reception at 5 p. m. will conclude the program for Saturday.

Reports from the various officers and committees of the Association will be brought be-

fore the Executive Council as information and for action Sunday. Attendance at this meeting will give new county medical society officers a quick review of the current program of the Texas Medical Association.

The conference of county medical society officers held in conjunction with the annual session in Dallas last spring met with such pleasing response that an expanded program has been scheduled for the coming year. In addition to the meeting in Austin in January, a series of "public relations clinics" to work out local problems will be held in the districts and a portion of the program at the annual session in Houston in April will be devoted to some of the practical nonmedical problems of individual doctors and of county societies.

Complete rosters of incoming county medical society officers should be reported to the central office of the Texas Medical Association immediately following elections so that the incumbents for 1953 will receive proper advance notice of the January conference.

Each county medical society in Texas should be represented at the officers' conference by at least one physician and preferably more. The information to be had at that time will enable county officers—especially those who have not served previously—to become oriented to their jobs and to the helps which await their asking from the Texas and American Medical Associations much more rapidly than would be possible otherwise. With this initial impetus, the doctors of the state should move forward together throughout the year, more aware than ever of each other's problems, responsibilities, and potentialities and of the services and facilities which their professional organizations offer.

At Christmas Time

» » There is nothing I can give you which you have not; but there is much that, while I cannot give, you can take. No heaven can come to us unless our hearts find rest in it today. Take heaven. » » No peace lies in the future which is not hidden in this present instant. Take peace. » » The gloom of the world is but a shadow behind it, yet within reach, is joy. Take joy. » » And so, at this Christmas time. I greet you with the prayer that for you, now and forever, the day breaks and the shadows flee away.

Fra Giovanni, 1513

(From a Christmas card published by the Fellowship of Reconciliation.)

"TO LIGHT ONE CANDLE"

"The curious assumption . . . that tuberculosis is no longer a major problem in the United States today is not only at variance with the facts but is downright dangerous." These words of Miss Mary Dempsey, statistician for the National Tuberculosis Association, explain why the efforts of workers in the field of tuberculosis should not be decreased but rather should be intensified.

Texas doctors have only to look within their state to see how far from ideal the situation is. The state's tuberculosis control program is sadly lacking in many ways. Among states Texas stands sixth in population, but forty others claim lower tuberculosis death rates. A Texan dies every four hours from the disease.

During 1951 more than half of the 1,962 deaths of Texans from tuberculosis reported to the State Department of Health occurred in homes. On July 31, 1952, 230 patients were on the waiting list for admissions to state sanatoriums. More than 2,000 beds are needed to meet even the old recommended minimum standard of 2½

beds for each annual death, which has been considered inadequate for some time.

State tuberculosis hospitals are handicapped by not having sufficient qualified personnel either because of inadequate appropriations for salaries or poor living accommodations. The high rate of 67.2 per cent of patients who left state tuberculosis hospitals in 1951 against medical advice could be reduced by employing medical social workers, occupational therapists, and rehabilitation counselors. The first full time vocational counselor was added to the staff of a state sanatorium only this year.

Although the case-finding program in tuberculosis has made tremendous strides in recent years (more than 700,000 Texans being screened in original chest examinations and rechecks in the year prior to May, 1952), it should be extended. Twenty-two Texas counties have never had a microfilm chest x-ray survey. In 1951, only 4,415 new cases of tuberculosis were reported to Texas public health authorities. This number represented a ratio of 2.2 cases per death (1,962 deaths were reported for that year), yet public health studies indicate that a ratio of 10 cases to each annual death exists in any given community. This means that only about one-fourth of the estimated 20,000 cases in Texas were known to be under medical supervision.

The importance of the general practitioner in detecting new cases of tuberculosis cannot be overemphasized. He is in an excellent position to discover the disease while he is performing routine general physical examinations, and he should include tests for tuberculosis as a part of the examination. He also should urge patients who are known to have the active disease and who are living in the community instead of a sanatorium to remain under medical supervision.

These are only a few aspects of the tuberculosis problem in the state. The Texas Tuberculosis Association's annual Christmas seal sale, which began November 25 and will continue until December 25, is an excellent opportunity for physicians to support the continuing battle against the disease and to urge patients and friends to contribute as well.

This year's Christmas seal, showing a lighted candle with the familiar double-barred cross, symbolizes the need not only for further enlightenment of the public in respect to tuberculosis but also of medical workers through adequate research, better means for diagnosis and treatment, and better application of public health measures for controlling the disease.

STRONGER MEDICAL PRACTICE ACT PROPOSED

Discussion has been under way for some time regarding the obstacles to the enforcement of and the unsatisfactory recourse in malpractice cases under the Medical Practice Act. As a result plans have been made by the Texas Medical Association to sponsor in the forthcoming session of the Legislature a measure designed to strengthen the Board of Medical Examiners, especially in granting the board power to revoke, cancel, or suspend licenses with the provision that the person whose license is so revoked, canceled, or suspended can appeal the decision of the board to the district court of the county in which he resides. Other changes recommended will give the board the necessary funds to carry on its work.

According to the present Medical Practice Act, the Board of Medical Examiners has the power to examine an applicant and grant or refuse him a license. After the license is issued, this board has no power to revoke or suspend the license; the law only gives the board the power to recommend to the district courts the revocation of a license.

At the past two or three meetings of the Council on Medical Jurisprudence of the Association, members of the State Board of Medical Examiners were invited to review the problems met by the board in enforcing the law. The board members stressed that they were handicapped in their work by the large number of complaints and the lack of money available on which to operate and for law enforcement purposes. In a report to the Executive Council of the Association in January, 1952, the Board of Medical Examiners stated that there were cases as old as 1949 on which no action had been taken.

With increasing complaints and difficulties encountered by the members of the board, changes in the present Medical Practice Act are vitally needed to enable the board to uphold the high standards of medical practice to which the great majority of doctors of medicine adhere and which the people of the state deserve. County medical societies as well as the individual physician and the patient must work together to strengthen our legislative measures to help assure skilled, ethical medical care.

DR. TRAVIS IS NATIONAL GP

Dr. J. M. Travis of Jacksonville, named last spring by the Texas Medical Association to represent the state as its General Practitioner of the Year, was chosen by a secret committee of the American Medical Association to be General Practitioner of the Year for the entire United States. The selection was made during the A.M.A.'s clinical session in Denver earlier this month.

Dr. Travis and the calf-hide covered biographical volume sent to the A.M.A. with his nomination were warmly received by members of the A.M.A. and its Woman's Auxiliary and were given nationwide coverage by newspapers, radio, and television.

The Texas Medical Association is to be congratulated on its choice of such a delightful person as well as such a skilled physician and civic leader to represent the state. Texans are proud of the well deserved honor which has come to Dr. Travis.

Additional details about the Denver meeting of the American Medical Association will appear in the January JOURNAL.

Texas Fellows of American College of Surgeons

Forty-eight Texans were conferred fellowship in the American College of Surgeons during its recent annual meeting in New York. They include Drs. Joseph F. Alsop, Corpus Christi; Billie L. Aronoff, Dallas; Robert C. Barker, Fort Worth; Joseph M. Barnhart, Houston; Fred W. Braastad, Houston; William W. Brown, Waco; Ralph Citron, Amarillo; Denton A. Cooley, Houston; Roscoe B. G. Cowper, Big Spring; Louis Daily, Jr., Houston; Gus F. Eckhardt, San Angelo; George Evashwick, Gainesville; Edwin E. Garrett, Houston; H. M. Gibson, Jr., El Paso; Charles H. Harris, II, Fort Worth; Nathan Harwood, Houston; Jerome C. Hohf, Marlin; Willis H. Jondahl, Harlingen; J. Randolph Jones, Houston; and Adolph F. Kauffmann, III, Fort Worth.

Also, Francis J. Kelly, Amarillo; Ernest M. Kimbrough, Haskell; Joe W. King, Houston; Walter B. King, Jr., Waco; Louis A. Kregel, Dallas; Heinrich Lamm, La Feria; Abel J. Leader, Houston; Roy T. Lester, Abilene; Albert O. Loiselle, Dallas; Carlo B. Marcum, Jr., Big Spring; Thomas P. Marinis, Midland; Walford D. Marrs, Fort Worth; Ernest A. Maxwell, San Antonio; Eugene G. McCarthy, Hale Center; William H. Merritt, Texarkana; Charles R. Morris, Dallas; Robert A. Murray, Temple; William P. Philips, Greenville; Gordon A. Pilmer, San Angelo; William L. Porter, San Angelo; John H. Selby, Lubbock; Robert W. Shirey, Hillsboro; Cecil Stell, Dallas; John M. Thiel, Galveston; Edward F. Thomas, Amarillo; Harold Warshaw, Lubbock; William R. Whitehouse, Cleburne; and Levon David Wright, Corpus Christi.

WARNING ON USE OF NEW DRUG

A warning that use of a relatively new antifungal drug, Asterol dihydrochloride, may be dangerous to young children was issued in the November 8 issue of *The Journal of the American Medical Association.* Six cases in which children suffered toxic mental reactions believed to be a result of use of the drug were reported by three groups of physicians from various parts of the country. The physicians believe the compound to be a central nervous system irritant. The children were given the drug to combat ringworm and other skin irritations. Although the doctors state that definite causal relationship between the drug and the mental reactions could not be drawn, evidence pointed to the drug as the reason for the complications.

"The incidence [of toxicity from the drug] cannot be calculated at present, but it can be roughly estimated at less than one per thousand children of all ages who are receiving treatment. It seems wise to avoid the use of this medicament entirely in very young children, and even to caution against the frequent use of large quantities over extensive body surfaces in older children," wrote four Los Angeles physicians.

ORIGINAL ARTICLES

Urinary Obstructions in Children

GRANT F. BEGLEY, M.D., Fort Worth, Texas

FROM time to time the newspapers across the country carry heart-rending tales of children celebrating Christmas in July or October because it appears that the child will not live until the next Christmas. Often these cases are of urinary obstruction with hydronephrosis or renal damage, and often the child does not live until Christmas. Even more pitiful in my estimation are those who, as a result of the publicity, get in the hands of physicians who perform life-saving surgery and prolong the child's life, but only for one, three, five, or perhaps ten years. During that time the child continues to have fever, recurrent pyelonephritis, and gradually increasing renal failure, and he is completely miserable, unhappy, unhealthy, underdeveloped and eventually dies of uremia or intercurrent infection.

These cases have appeared in the medical literature as well as newspapers and news magazines, and there is really nothing new to say about them, no new techniques devised for them. Some of the cases that I will present illustrate the sort of situation mentioned.

Figure 1, made after a barium enema, gives a good indication of the sort of thing observed when the kidneys are filled with radiopaque dye. The attempted filling by the intravenous method in a child such as this is not satisfactory, but it gives some indication of disease (fig. 2). Cystoscopy and retrograde pyelograms give further indication of the extent of damage sustained in this 5 year old child (fig. 2 right). Illustrating the apparent futility of it all at times, figure 3 is a retrograde pyelogram on a 3 month old child made by inserting contrast medium through a nephrostomy tube on the left; the medium filled that side and the bladder and backed up into the other side. It is obvious that this damage did not begin at birth and did not progress to this point in three months. It illustrates the fact that urine excretion begins in fetal life probably at least as early as the sixth month. This represents a rare sort of lesion, and fortunately hydronephrosis of this magnitude in young children will not be encountered by many physicians. It serves to illustrate the sort of thing that does happen and that may be overlooked by good physicians, including pediatricians.

Read before the Section on Pediatrics, Texas Medical Association, Annual Session, Dallas, May 6, 1952.

NEED FOR UROLOGIC STUDY

The main purpose of this paper is not to consider cases such as those just mentioned but to consider primarily cases of much less magnitude which are seen early and observed for some time because of various complaints, of seeming unimportance, but which result in conditions such as in figure 4, showing bilateral hydronephrosis which develops in a young adult and which is terminated by slow death.

Let us consider first the history given by these patients and their parents. For periods varying from two to three months in infants to twelve to fifteen years in older patients, some of the following symptoms have been noticed and found on taking a careful history: pyuria; disturbances of urination (dysuria, frequency, urgency, and so forth); hematuria, except in nephritis; abdominal pain; abdominal tumor; anomaly of the external genitalia; urogenital injury; spinal cord injury and disease; enuresis; renal insufficiency; retarded growth; hypertensive vascular disease; and albuminuria. The most common and persistent finding is pyuria.

Figure 5 *left* shows an intravenous urogram on a 3 year old child who for two of her three years had recurrent attacks of pyuria, sometimes associated with apparent discomfort on urination. The pus had been treated by various combinations of drugs with no attempt to isolate the organism or to determine the reason for the recurrent infection. This child was well-developed for her age, had had no infections of the upper part of the urinary tract so far as clinical history would indicate, and had none of the other findings just enumerated except enuresis, which is probably not significant in a 3 year old. Although these pyelograms give no positive information, they do suggest recurrent pyuria, not due to obvious obstructions but apparently due to an antibiotic resistant organism of some kind.

For a year the flare-ups of discomfort, frequency, and urgency were kept fairly well under control by various antibiotic agents, streptomycin and terramycin chiefly, but the condition never cleared up completely. Approximately one year from the first examination, pyelography was done again, revealing asymmetrical enlargement of the bladder obviously due to some urethral or bladder neck obstruction (fig. 5 right). There was no damage to the upper urinary tract. At this point cystoscopy was done and no bladder abnormality was noted, but a little obstruction in the neck of the bladder was seen. This was enough to have caused the dilatation of the bladder seen on the roentgenograms. The bladder neck was dilated with sounds through size 24, and with the urethral opening thus well dilated, concentrated treatment with terramycin, to which the organism was most sensitive, was started.

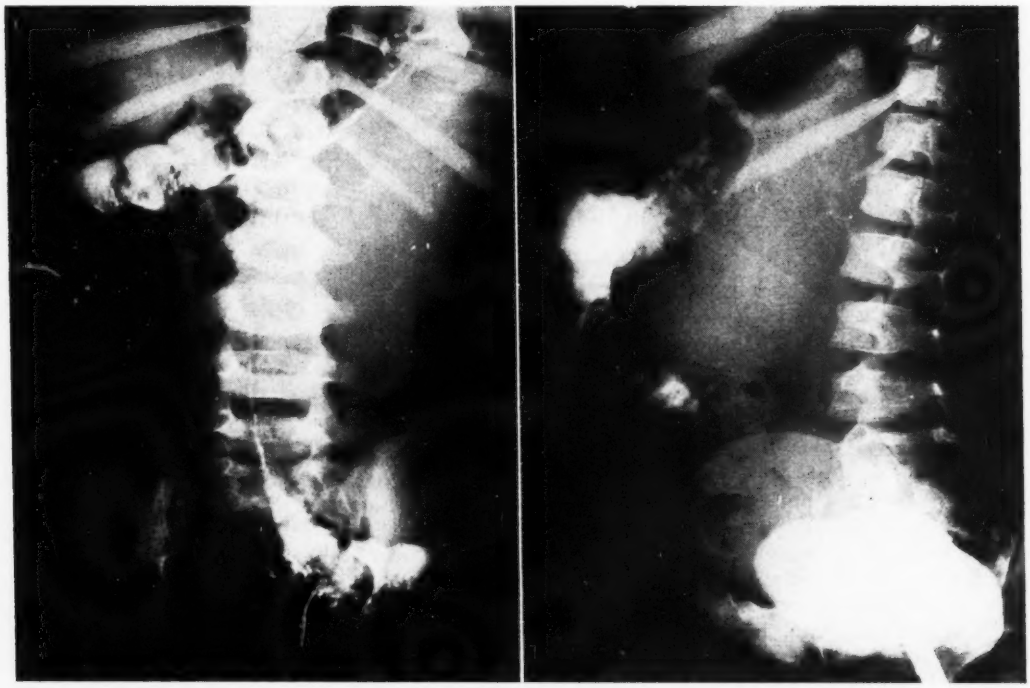

FIG. 1. Anteroposterior and lateral roentgenograms made after a barium enema, showing bowel displacement anteriorly and medially by a large, left retroperitoneal mass.

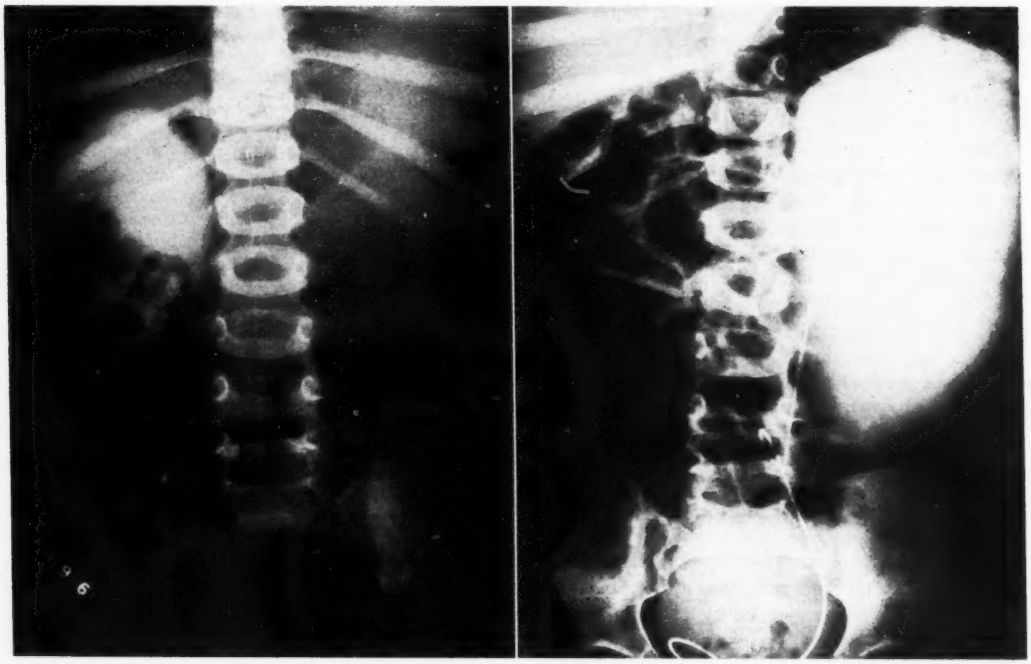

FIG. 2. Left. Intravenous urogram showing large hydronephrosis of the right kidney and no apparent function on the left.

Right. A left retrograde pyelogram of the same patient giving further evidence of damage.

This case is now at this stage and it is hoped will progress no further. However, the next step, if necessary, is to resect or otherwise remove the fibrotic area at the bladder neck to insure ease and complete drainage of the bladder. It is believed that this case, if untreated, would continue to show gradual enlargement of the bladder until bilateral dilatation of the ureters and hydronephrosis would result.

Figure 6 shows a film of a 4 year old child who had voided bloody urine on three or four occasions. The roentgenogram shows the congenital anomaly of complete ureteral and pelvic reduplication. In the region of the ureterovesical

FIG. 3. Urogram made by filling the left nephrostomy tube and showing reflux up the right ureter in a 3 month old patient.

junction is a double opacity which represents a ureterocele with a stone formed inside it. This obstruction was not removed at once because the parents objected. For nearly a year the child continued to have bouts of hematuria and developed infection for which she was given sulfonamide treatment chiefly. During that time dilatation, damage, and enlargement of the ureterocele developed. Removal of the obstruction and stone has now been accomplished surgically, and treatment appears to have cleared up the infection completely. There should be no further difficulty.

In 1945, Dr. Meredith Campbell[1] reported 26 children with upper ureteral blockage by anomalous renal vessels in whom abdominal pain was the prominent or presenting symptom. Seven of these had already had their appendix removed. The majority of these patients did not have urinary tract infection. For appendectomy there needs to be no apology. In the face of an acute abdominal pain on the right or sometimes even on the left, without specific indication of urinary tract involvement, appendectomy is the conservative and only sensible thing to do. However, it must be remembered that abdominal pain of urinary tract origin does not necessarily appear to be coming from the kidneys. Soley reported 19 cases of hydronephrosis, 10 of which had no symptoms except nausea and vomiting.[5] Acute abdominal pain of urinary tract origin is not limited to disease of the ureteropelvic area. Hypotonia with vesical distention also may pro-

FIG. 4. Urogram made by filling the bladder only and showing hydronephrosis in a young adult.

duce abdominal pain which is not necessarily suggestive of urinary tract involvement.

The point that I have attempted to illustrate with these urograms and cases is that persons who present obstructive lesions with irreversible damage invariably have a history which makes the urologist wonder why it was not noted before. Although hindsight is not diagnostic, perhaps we may use it in considering what sort of pediatric problem should be investigated urologically. I firmly believe that these tests are well within the realm of the pediatrician's practice, and I am certain that much of the preliminary urologic investigation should be done there. There should be an awareness of this problem in an effort to prevent the development of dramatic, irreversible, fatal, hydronephrosis. Urologists do not attempt to look down

their cystoscopes and deride any other member of the profession who has failed to diagnose what urologists think is obvious. The correct diagnosis is not obvious at the beginning when diagnosis is most difficult.

STEPS IN UROLOGIC STUDY

Let us consider now what should constitute a urologic work-up on children who present problems such as have been discussed. Let me emphasize that urologic investigation is indicated when there is a suspicion of trouble in the urinary tract. It is much better to do many examinations without finding pathologic changes than it is to omit examination and permit some dire consequence to follow. The following steps should be taken in a urologic examination:

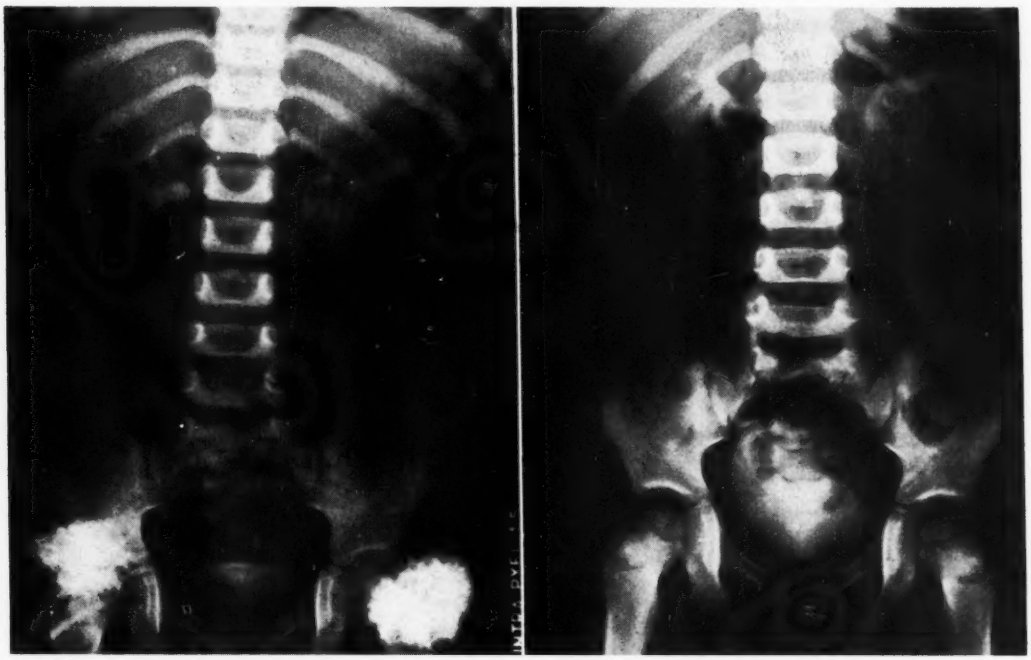

FIG. 5. Left. Excretion urogram made by intramuscular injection of Diodrast showing no abnormality. Right. Excretion urogram (intravenous) in the same patient made approximately a year later and showing asymmetrical enlargement of the bladder.

1. Routine urinalysis should be done. This includes not only the usual procedures but also some method of staining the dried urinary sediment if pyuria is found. It is appalling how often this is not done, either in large laboratories or in physicians' offices. The logic of it is inescapable; when pus is found in the urine, some attempt, preferably a gram stain because it gives the most information, should be made to identify the group to which the organism causing the infection belongs. Often upon finding pus in the urine, the physician immediately prescribes either sulfonamides, penicillin, or some other drug picked by guesswork. In my experience penicillin is the most overworked drug on the market today. If the gram stain of the urinary sediment with pus shows gram-negative bacilli, as it does about 85 per cent of the time, administering penicillin is like pouring Chanel No. 5 in the barnyard; it has no noticeable effect. Likewise if the organisms prove on gram stain to be a coccal type and give a gram-positive stain, the administration of sulfonamides is usually futile. There is considerably more to be said in favor of the combination of penicillin and streptomycin given simultaneously when knowledge of the organism is lacking, but we have been taught that shotgun prescriptions are to be avoided, and certainly no advantage can be seen in giving penicillin with streptomycin when only one or the other is indicated.

2. The next step in the investigation of recurrent urinary tract difficulties, and particularly if the initial treatment does not result in a complete cure, is to gain information about the organism causing the trouble. Cultures of the urine are definitely indicated in this sort of case, as are somewhat newer techniques of sensitivity tests designed to determine which of the available antibiotic drugs is the best. In approximately forty-eight hours a urine culture can be reported from a trustworthy laboratory giving the first and last name

and middle initial of the bacterial culprit. It is then easy to pick one of the antibiotic agents based on logic and science. However, sensitivity tests of urine can be done readily in the following manner: a sample of the urine, collected by catheter from females, is mixed with the agar, poured into the plate, and allowed to solidify. Then disks or tablets containing various concentrations of the drugs under consideration are placed in some logical manner on the surface of this plate. As the organisms grow, zones of inhibition surrounding these tablets or disks are readily apparent. Within twenty-four hours the particular antibiotic agent causing the largest zone of inhibition is obviously the drug of choice. Figure 7 shows a simple test upon which logical treatment can be based and I recommend it highly.

FIG. 6. Excretion urogram showing bilateral ureteral reduplication with a ureterocele of one ureter on the right which contains a small calculus.

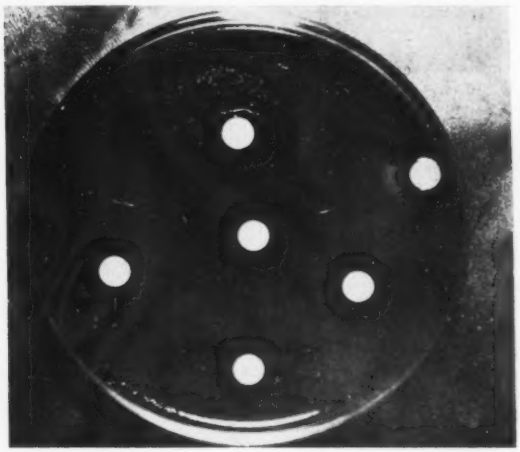

FIG. 7. Sensitivity test on a culture of urine showing zones of inhibition of growth of an infectious organism surrounding some of the antibiotic disks.

3. In urinary tract investigation the third step comprises roentgen-ray visualization of the urinary tract. An attempt is made to visualize the urinary tract by intravenous, or more correctly, excretory urography. Figure 5 *left* shows a normal excretory urogram in a 3 year old infant which was procured by the injection of 8 cc. of Diodrast into each gluteal area. This is considered to be a normal urogram, shows no particular pathologic change, and immediately eliminates the necessity for further urologic investigations of the upper part of the urinary tract unless further urologic symptoms occur. Usually, even in infants, the dye can be injected intravenously by an adept operator, but there is no particular contraindication to intramuscular injection of the dye, especially if used in conjunction with Hyaluronidase, which increases the rate of absorption and, therefore, the rate of excretion.

Excretory urograms can be made on children of any age as well as adults, and in the presence of average or normal function and using a few precautions, adequate visualization will be obtained. The technique is really simple; it consists of dehydrating the patient for approximately eight to twelve hours prior to making urograms. It is well to make the urograms when the patient's stomach is empty, but catharsis does not seem to add any advantage, especially in children. The technique used in my group is illustrated by figure 8, showing a 5 year old child on the x-ray table held in place by the abdominal band and rubber bladder which serves two purposes. First, it holds the child relatively still and in the same position while the series of urograms are being made, no matter how much he kicks his heels and squalls. The second and most important function of this apparatus is that it obstructs the ureters in their lower thirds, if applied correctly and tightly, so that better filling and better visualization of the renal pelves and calyces is thereby accomplished. Upon removal of the pressure apparatus another urogram is taken to allow for filling of the lower ureters and for more complete filling of the bladder. Often gas shadows in the bowel are so bad that visualization is obviously impossible. Figure 9 *left* illustrates this in a 3 month old infant. A handy trick in this situation described by Dr. Matthei[4] consists of giving the infant a bottle of milk after the

needle puncture and during injection so that the full stomach pushes the bowel out of the way and pictures of excellent diagnostic quality may be obtained (fig. 9 right).

4. The fourth phase in a complete urologic investigation is that of visualization of the bladder and lower

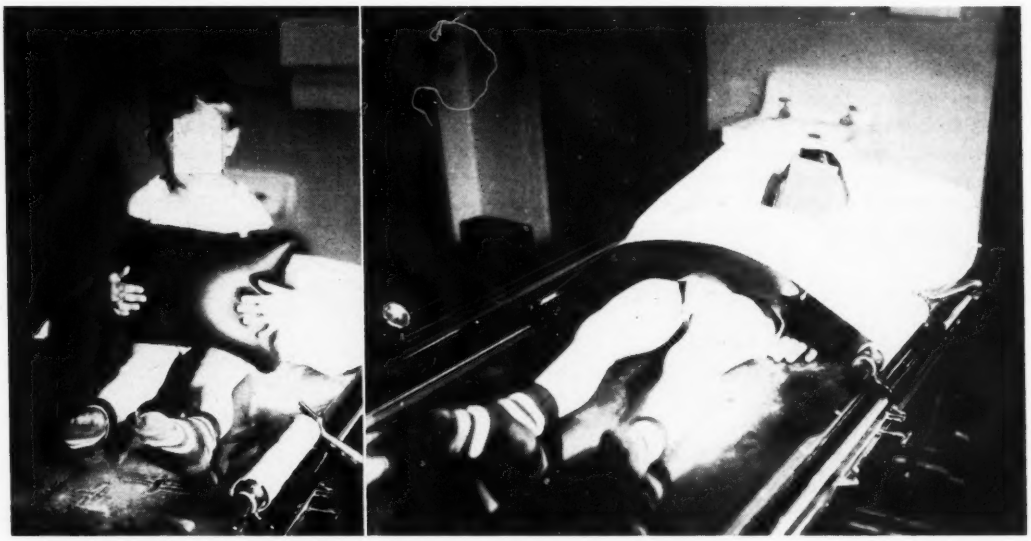

FIG. 8. Rubber bladder used for compression during excretion urography.

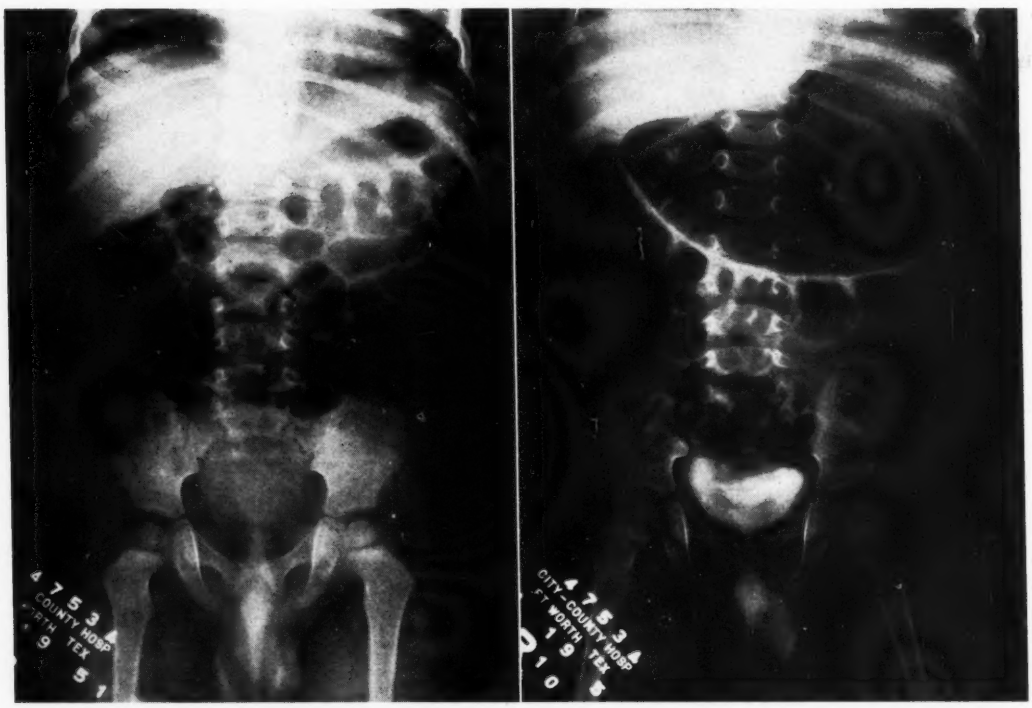

FIG. 9. Left. Scout film of an infant showing extreme distribution of gas which makes visualization of the urinary tract impossible.

Right. Urogram in which the stomach distended with milk pushes the gas-filled small bowel aside and allows good visualization of the kidney areas.

part of the urinary tract. This may be necessary because of poor function or other defects and because the upper urinary tract does not visualize with intravenous pyelography. Cystoscopy with the passage of catheters and retrograde injection of radiopaque substances is then necessary. However, it may be necessary even if the upper urinary tract appears to be perfectly normal, because symptoms may originate in the lower urinary tract. Excretory urograms and cystograms fail to show many varieties of lesions and abnormality in the neck of the bladder or in the urethra. Conditions such as valves of the posterior urethra, congenitally abnormal insertions of the ureters, hypertrophy of the verumontanum, and bladder neck fibrosis and contracture cannot be visualized on roentgenograms by any method and must be visualized cystoscopically.

TREATMENT

I have discussed treatment with antibiotic agents for infection but have not yet stressed the importance of removal of the obstruction so that drainage will be adequate, prompt, and complete in order for the infection ever to be cleared up permanently. Treatment must consist of removal of the cause, and this depends upon the character and location of the obstruction. If obstruction is in the ureter, it is most likely to be in the region of the ureterovesical junction. Approximately two-thirds of all ureteral obstructions are in this area and only one-third are in the region of the ureteropelvic junction. In the first instance dilatations with catheters and bougies may or may not be effective. In the case of obstructions at the junction of the pelvis and the ureter, no amount of dilatation will be effective and reparative surgery is certainly indicated. If the obstruction is due to abnormalities in the neck of the bladder, it may be removed by either dilatation with sounds, resection transurethrally using the infant resectoscope to remove the hypertrophied tissue and enlarge the opening, or by open surgery using the retropubic approach to the bladder neck for removal of fibrous bars, congenital flaps and valves, or other abnormalities at that area. Repair of obstructive lesions and the success thereof depends upon the skill and sometimes the imagination of the operator. They do not fall into identical categories and operations of various sorts must be improvised.

It will be noted that various neurologic lesions have not been considered since I do not believe that they are primarily obstructive in their origin. The physical findings, and to some extent the treatment, may be the same, but the prognosis is considerably less favorable and successful treatment requires much more ingenuity, skill, and luck than the successful repair of obstructive lesions.

CONCLUSIONS AND SUMMARY

All pediatric patients who present puzzling gastrointestinal symptoms, abdominal enlargements, disturbances in urination with or without laboratory findings, congenital abnormalities, and various other specified findings should have routine and complete urologic investigation early and perhaps repeatedly in order to prevent progression of obstructive lesions of the urinary tract to such a point that only renal failure and death will result.

Various phases of obstructions in the urinary tract have been considered and a routine plan for investigation of urologic problems in children has been presented. The importance, ease, safety, and relative dependability of excretory visualization of the urinary tract have been emphasized.

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ABSTRACT OF DISCUSSION

DR. A. O. MANSKE, Waco: Dr. Begley has brought to mind one important point, that is, staining the pus to determine what organism is causing the trouble.

The majority of cases of hydronephrosis are congenital in origin, but the condition may be due to pressure from an aberrant blood vessel that traverses the pelvis of the kidney or to partial obstruction of the ureter. Some of the rarer obstructions to the urinary tract may be caused by a neoplasm usually involving the kidney, kinked ureter, prolapsed kidney, or extreme phimosis.

Therapeutically it is well to divide the obstructive lesions into those occurring above and those below the bladder. Examination of the bladder by cystoscopy will reveal whether it is dilated, hypertrophied, or normal in appearance. An obstructing lesion below the bladder usually causes dilatation and hypertrophy. Obstructive lesions are twice as common proximal to the bladder as distal. Prostatic hypertrophy may cause urethral obstruction especially in cases in which Antuitrin-S is used in treatment for cryptorchism.

A rather rare form of obstruction also may be caused by diverticula of the ureters. This anomaly easily can be missed by either intravenous urogram or cystoscopic examination, but is brought out by retrograde cystoscopy. Pain usually is associated with this type urinary obstruction, and it is with this continuous complaint and negative urinalysis that appendectomies are performed on these children.

If all pediatricians would spend more time in getting an accurate history and carefully following up on the available laboratory procedures, fewer cases of hydronephrosis would result.

Use of Gastric Distention As an Aid to Pediatric Urography

DAVID H. ALLEN, M.D., Wichita Falls, Texas

STUDY of the urinary tract in adult patients can be done with relative ease and accuracy, but this is not so true in pediatric patients. The small caliber of the urethra makes cystoscopy difficult and less informative, but of even greater concern is the difficulty encountered in obtaining good quality intravenous urograms.

Small children are aerophagic and the small intestine of a child apparently has less ability to dispose of the swallowed air than does the small intestine of an adult. Usually a distracting mixture of feces and gas is found throughout the intestinal tract in children and particularly in infants. It is this overlying mixture of positive and negative densities which offers the greatest obstacle to good intravenous urograms and has led many physicians, particularly pediatricians, to feel that urograms are of little value in children. Therefore, this valuable procedure is used less than if satisfactory urograms could be routinely obtained.

In 1949, before the South Central Section of the American Urological Association, Matthei[2] outlined a procedure which usually produces diagnostic urograms in children. For about two years, I have used this procedure with such gratifying results that I believe it deserves repetition and wider use.

Matthei dehydrates all infants and small children for twelve hours unless this is specifically contraindicated. A scout film is made, after which the contrast medium is injected intramuscularly or intravenously. Immediately thereafter, a full 8 ounce bottle of the usual formula is given the infant or, in the case of small children, one or more 8 ounce glasses of plain or chocolate milk is offered. The ingested material distends the stomach, which in turn displaces the colon and small intestine leaving an unobstructed and undistorted view of the upper urinary tract through the homogeneous gastric shadow. The administration of a large quantity of milk at the beginning of the examination does not cause sufficient dilution of the dye to interfere with visualization. The ureters often are obscured, but the method almost always gives a good view of the pelves and calyces.

In older children, relatively larger amounts of milk are required to distend the stomach sufficiently to clear the renal areas. It is correspondingly more difficult to get patients' cooperation. The large amounts of milk, being of unit tissue density, decreases soft tissue detail. With these factors in mind, I began casting about for some other medium with less density and requiring ingestion of a smaller volume. Since the liberation of large volumes of carbon dioxide from ingested carbonated beverages has long been used to distend and study the gastric fundus, it seemed that this might be an effective way to distend the stomach during urography.

In children over 18 months of age, the substitution of Coca-Cola for milk has proved to be an effective refinement of the Matthei procedure. In infants under 18 months of age, this has failed to be effective because the patient burps up the medium. In an early report published in the urologic literature,[1] it was indicated that 14 to 16 months was the proper dividing line, but a year's further experience suggests that 18 months is a better age to change from the milk to carbonated beverage. The gaseous medium has yielded unusually good detail and for most children, Coca-Cola is a readily acceptable vehicle. The accompanying illustrations (fig. 1, 2, and 3) present four cases to show the effectiveness of milk and Coca-Cola.

SUMMARY

Matthei's procedure has been an effective and simple way of routinely obtaining diagnostic pyelograms in children under 18 months of age.

Since the use of Coca-Cola in older children gives better detail and is more easily administered, I believe it represents a useful refinement of the method. It gives such excellent soft tissue detail that it is helpful in scout films of the upper part of the abdomen in children as well. Therefore, I believe that in pyelograms on children over 18 months of age, Coca-Cola rather than milk should be used to distend the stomach.

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Read before the Section on Radiology, Texas Medical Association, Annual Session, Dallas, May 6, 1952.

Wichita General Hospital.

ABSTRACT OF DISCUSSION

DR. CAROLINE ROWE, Galveston: The procedure which has been discussed is worth while, and its simplicity makes it available to anyone. There is no contraindication to my knowledge. The patient is dehydrated when the opaque me-

dium is injected, and the milk or Coca-Cola is not absorbed rapidly enough to interfere with visualization of the medium excreted by the kidneys. Good visualization has been obtained as long as fifty minutes after the examination has begun.

I should like to point out also that this method gives excellent visualization of the spine. I have seen cases with questionable abnormalities of the spine from the tenth thoracic to the fifth lumbar vertebrae which were largely obscured by intestinal shadows, and the ingestion of the chocolate milk when the stomach was empty provided visualization of the spine when it could not otherwise be seen.

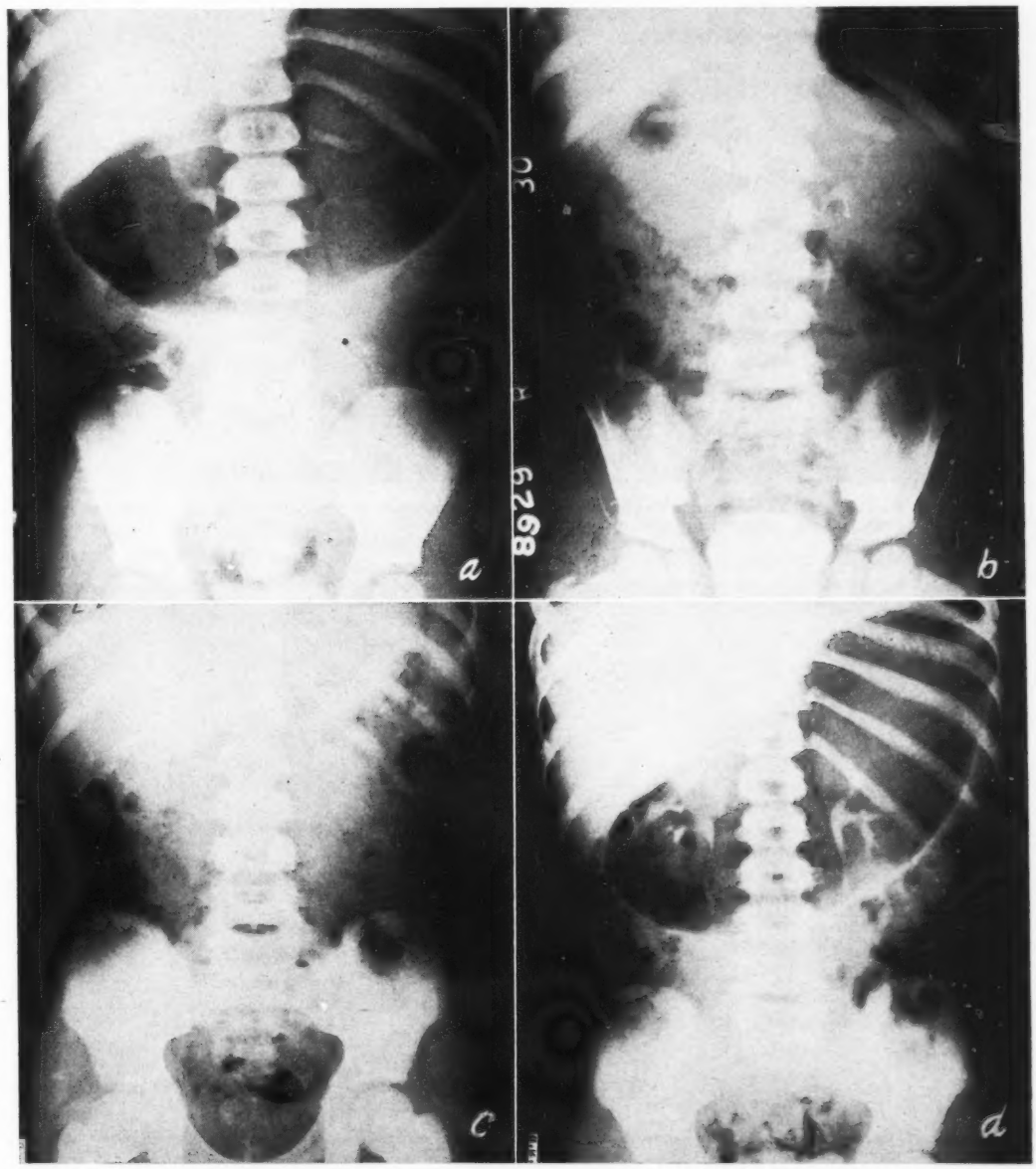

FIG. 1a. Urogram of a 4 year old girl made eight minutes after intravenous injection of Neo-Iopax and five minutes after ingestion of Coca-Cola.

b. Urogram of the same patient made thirty minutes after intravenous administration of Neo-Iopax. Note that the gas has been lost from the stomach by "burping."

c. A scout film of a 7 year old boy made prior to administration of Neo-Iopax.

d. Urogram of the same boy made fifteen minutes after intravenous administration of the contrast medium and ten minutes after ingestion of Coca-Cola.

Finally, but of equal importance, is the psychologic aspect of giving these children something good to drink. After all, they are hungry, thirsty, and irritable, and are in a strange place. Just promising the child a Coke or milk establishes a friendlier relationship. After committing the unpardonable act of sticking him with a needle, the physician by offering the drink is put on friendly terms once more with the patient.

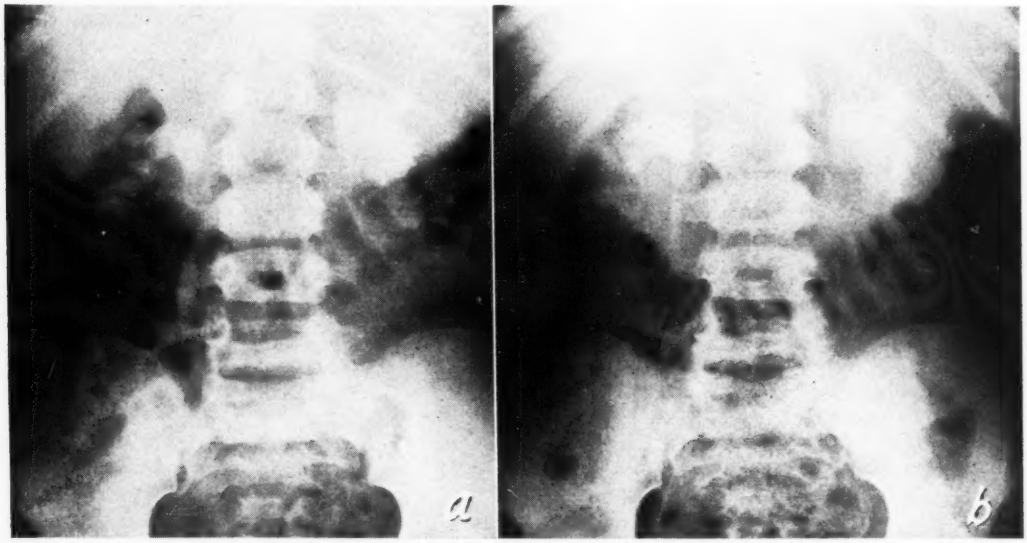

FIG. 2a. Urogram of a 5 year old boy made fifteen minutes after intravenous administration of the medium. The colon lies over the lower pole of both kidneys.

b. Urogram of the same patient made ten minutes later after ingestion of 6 ounces of a noncarbonated beverage. The stomach has displaced the colon downward.

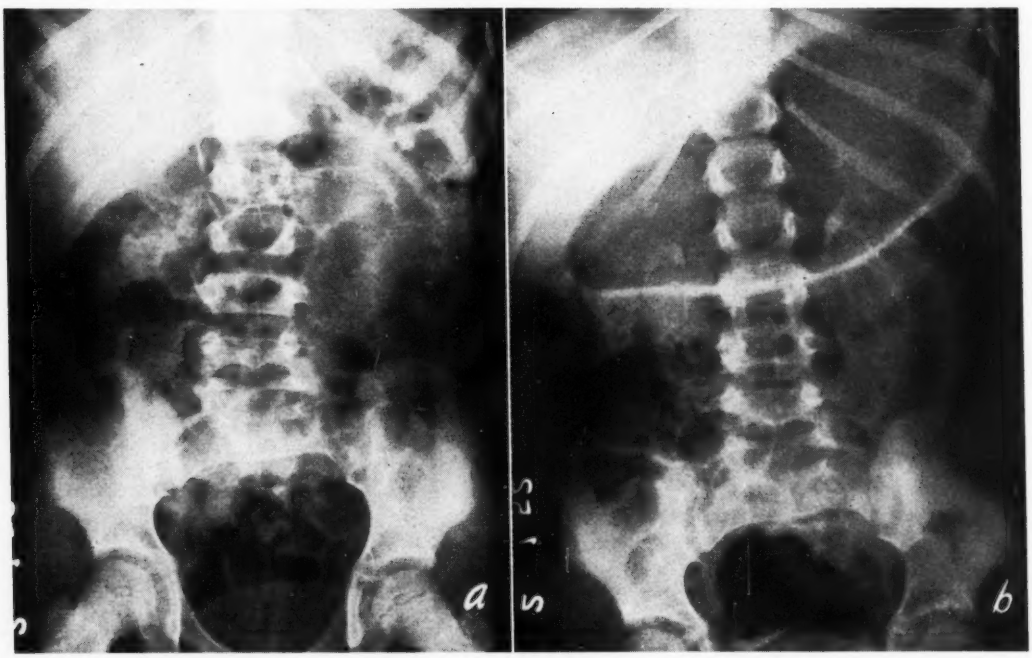

FIG. 3a. Scout film of a 7 year old boy made without preparation of the patient.

b. Urogram of the boy made fifteen minutes after intravenous administration of Neo-Iopax and ten minutes after ingestion of Coca-Cola.

An Epidemic of Acute Nephritis in South Texas

ERNEST E. MILLER, M.D., Beeville, Texas

IN the years 1948, 1949, and 1950, approximately 50 cases of acute nephritis were reported in an area of three counties (Bee, Live Oak, and the northwest part of San Patricio Counties) embracing a population of about 40,000 people. These cases were reported by nine physicians; I observed 30 of the cases, either directly or indirectly. Acute nephritis had previously been considered a rarity in this section.

CASE REPORT

The following is a report which is rather typical of those cases included in the series.

H. S., an 8 year old white boy, was seen in the physician's office July 2, 1949, with the chief complaint of fever and general malaise of twenty-four hours' duration.

General Physical Examination. — No abnormal findings were observed other than generalized mild redness of the throat and a temperature of 101 F. The patient did not appear unduly ill. The blood pressure was not recorded.

Laboratory Data.—Urinalysis revealed a specific gravity of 1.018; albumin, sugar, and microscopic examination were negative. The white blood cell count was 7,400 with a differential count of 61 per cent neutrophils and 39 per cent lymphocytes.

Course of Disease.—On the patient's first visit to the office no treatment was instituted. Twenty-four hours later the patient was returned to the office with the chief complaint of "swelling all over." There was moderate swelling of the face, hands, and feet. The temperature had dropped to 98.4 F. The blood pressure was 150/98. Urinalysis revealed specific gravity of 1.036, albumin 4 plus, and red blood cells 1 plus. Granular casts were numerous. Viewed in the light of previous cases treated with a similar illness, the patient was not considered ill enough for admission to a hospital. At this time 300,000 units of procaine penicillin intramuscularly was ordered daily for six days and bed rest was instituted.

Fourth day of illness: The swelling of the face, hands, and feet had become moderately extreme. The blood pressure was 160/128. Urinalysis revealed smoky colored urine, albumin coagulated on heating, red blood cells 3 plus, white blood cells 1 plus, and casts of all varieties too numerous to count. The amount of urine voided in twenty-four hours was 130 cc.

Ninth day of illness: The swelling slightly decreased; blood pressure was 155/130; results of urinalysis were unchanged; and total urine voided in twenty-four hours was 800 cc.

Twentieth day of illness: Swelling was totally absent; blood pressure was 130/90; urinalysis showed albumin 1 plus, an occasional hyalin cast, and no red or white blood cells.

Thirty-fourth day of illness: Blood pressure was 108/80. Urinalysis revealed a heavy trace of albumin; other tests were negative.

Forty-sixth day of illness: Blood pressure was 92/66; urinalysis showed a specific gravity of 1.018, with albumin, sugar, and microscopic examination negative; total urine excreted in twenty-four hours was 1,400 cc.

This patient had no fever after the second day of illness, and at no time did he appear to be desperately ill. He was allowed to return to school and normal activity after the forty-fourth day of illness. Six subsequent monthly examinations failed to reveal any deviation from normal in his blood pressure or urine examinations.

REVIEW OF CASES

Of the 50 cases reported only 6 patients were considered ill enough to require hospitalization. Two of these had almost complete anuria and convulsive seizures over a period of forty-eight hours. None of the 50 cases resulted in death.

The 44 cases treated at home were moderate to mild in their courses. The minimum criterion of diagnosis was the urinary finding of 4 plus albumin with granular casts, accompanied by an elevation of the diastolic blood pressure (as judged by the physician in charge). In most instances there was marked elevation of both diastolic and systolic pressures.

In all patients the blood pressure readings and the urinalysis results had returned to normal in from one to six months.

There was only 1 with recurrence of symptoms; that occurred in a child one year after the original attack of nephritic syndrome. The second attack ran a course similar to the first.

Ten cases were in adults from 20 to 50 years old. The remainder were in children 3 years of age or older.

Four families had 2 members affected. In a family of 4 children each child became ill at intervals of three weeks, six months, and one year respectively. An uncle was exposed for a few hours to the first child and then isolated, only to begin a similar nephritic course three weeks later. Then three weeks after onset of the disease in the uncle one of his children became ill. One other child, exposed to the original patient for a few hours, returned to her home in San Antonio and three weeks later began a similar course of illness. This evidence seemed to suggest an incubation period of three weeks from time of exposure.

FURTHER OBSERVATIONS

There seemed to be attenuation in virulence of infection toward the end of the epidemic (in the last year reported).

In 1950, the last year covered by this series, I observed 4 cases of unexplained, and otherwise symptomless, hematuria of one week average duration. These were thought to be mild hemorrhagic nephritis with possibly the same etiologic background as the other cases reported in this paper.

Cases were widely scattered over both rural and urban territory. The disease was no respecter of race or financial status.

dosage on the cases occurring in 1948 and 1949. Subsequent cases were treated with Chloromycetin or Aureomycin. None of these antibiotic drugs were thought to change the course of the illness. However, the latter two (having a wider range of effectiveness for bacterial and virus invaders) would seem more logical to use until the etiologic organism can be determined.

QUESTIONNAIRE SURVEY

A questionnaire was sent to 619 physicians in 32

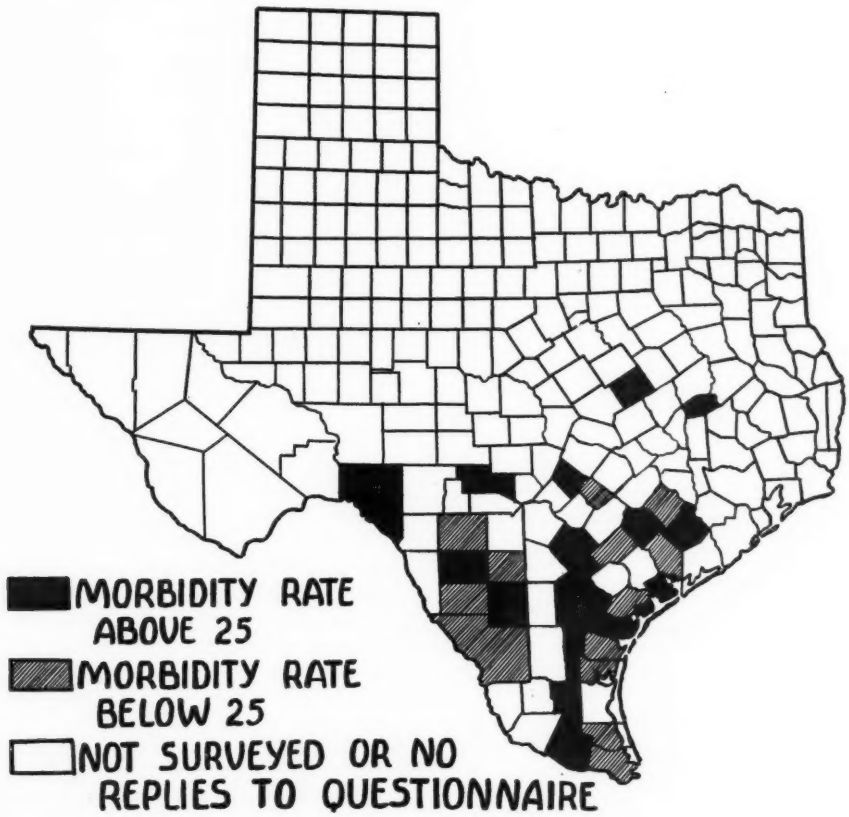

FIG. 1. Map of Texas showing the area covered by a mail survey and indicating the morbidity rate per 100,000 population per year of acute nephritis reflected in replies to the questionnaires.

There was no evidence of a common water or milk supply.

All doctors in the area had found acute nephritis to be a rarity in their practice in the many years prior to the three year period cited. There have been no more cases reported in the past six months.

Approximately one-third of the cases reported had no prodromal symptoms of infection in the upper respiratory tract nor fever.

As for treatment, penicillin was used in adequate

counties in south Texas (fig. 1) asking, "Approximately how many cases of acute nephritis have you seen in the past three years?" Of those, 129 doctors reported a total of 722 cases and 139 reported having seen no cases; 351 did not reply to the questionnaire (table 1).

Eighteen doctors reported between 10 and 20 cases each; four reported more than 20. One doctor added the terse note: "Fourteen cases; all were children; 10 are dead, including my son." The counties surveyed,

representing a population of approximately 975,773 people, had 722 cases reported in three years giving a morbidity rate of 24.7 cases per year per 100,000 population.

Admittedly this questionnaire was oversimplified in wording to increase the percentage of returns from busy doctors. Also is admitted the probability of inaccuracy of any survey conducted by mail. However, it was hoped that such a survey would help localize the geography of the epidemic reported in this article. No such localization was produced (fig. 1).

TABLE 1.—*Morbidity Rate of Acute Nephritis As Reported By Counties.*

County	Cases in 3 Yrs.	Population 1950	Cases per Yr. per 100,000 Pop. (Morbidity Rate)
Aransas	8	4,252	62.7
Bee	30	18,174	55.0
Brooks	10	9,195	36.3
Caldwell	6	19,350	10.3
Calhoun	7	9,222	25.3
Cameron	46	125,170	12.3
Colorado	2	17,576	3.8
DeWitt	2	22,973	2.9
Dimmit	5	10,654	15.6
Falls	27	26,724	33.7
Frio	2	10,357	6.4
Hays	11	17,840	20.6
Hidalgo	139	160,446	28.9
Jackson	1	12,916	2.6
Jim Wells	24	27,991	28.6
Karnes	14	17,139	27.2
Kerr	11	14,022	26.1
Kleberg	12	21,991	18.2
LaSalle	5	7,485	22.3
Lavaca	19	22,159	28.6
Live Oak	9	9,054	33.1
Madison	20	7,996	83.4
Nueces	110	165,471	22.2
Refugio	6	10,113	19.8
San Patricio	64	35,842	59.5
Uvalde	6	16,015	12.5
Val Verde	27	16,635	54.1
Webb	20	56,141	11.9
Wharton	35	36,077	32.3
Willacy	15	20,920	23.9
Wilson	13	14,672	29.5
Zavala	16	11,201	47.6
Total	722	975,773	Aver. 24.7

REVIEW OF LITERATURE

A review of the literature reveals two interesting recorded "epidemics" of acute nephritis. One was recorded in the industrial city of Greenock, Scotland, in the years 1945 and 1946.[1] The approximate morbidity rate was 583.8 cases per 100,000 population per year. Another epidemic was noted in a Palestine Arab refugee camp at Armman, Transjordan, in 1948 and 1949.[2]

SUMMARY AND CONCLUSIONS

An "epidemic" of acute nephritis in three South Texas counties was observed.

A majority of the cases were immediately preceded by two days of mild infection of the upper respiratory tract.

A contagious feature was thought to be evident in some cases.

There were no deaths in 50 cases (no credit was given to treatment used).

An additional 722 cases of acute nephritis were reported in a survey of 32 counties for a three year period.

This epidemic of acute nephritis is roughly recorded in the hope that physicians in other areas will be alert to the possibility of such an epidemic appearing in their communities and will make every effort to determine the causative organism. I will be glad to act as a clearinghouse for all such information.

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Beeville Clinic.

REASONS FOR SCARCITY OF MEN

For the first time in American history, the 1950 census revealed, there are more women than men in the nation; 1,430,000 more women.

In the November 22 issue of *The Journal of the American Medical Association* it was reported that the ratio of women to men will increase with attendant increase in widowhood and dependency. The age group in which the greatest difference occurs is over 45 years where women outnumber men 1,000 to 956. Reasons for the predominance of women include the higher death rate of males and the changing pattern of migration into the United States with more women migrating to the country and more men than women leaving the country. A net gain of 181,500 women over men occurred by migration during the five years immediately after World War II. The editorial in the publication further attributed the large margin between the male and female population to war deaths, stating that were it not for war losses, the present excess of American women over men would be about one-third of a million less.

ENZYME HELPS PREVENT KIDNEY STONES

Hyaluronidase mixed with isotonic sodium chloride solution has aided in the prevention of kidney stones, it is reported in the November 15 issue of *The Journal of the American Medical Association.*

A study of twenty-four persons in whom kidney stones previously formed at a rapid rate showed that injections of the drug under the skin every twenty-four to forty-eight hours prevented the formation of new kidney stones and prevented further growth of existing stones, states the article. In four patients, the size of the existing stones became smaller and less dense.

The effect of the drug is manifest within thirty minutes, the article relates, and persists for twenty-four to seventy-two hours. Dosage varies according to individual needs; however, it was pointed out that insufficient dosage might result in the exact reverse of the intended purpose. According to the article, an overdose of hyaluronidase does not produce adverse effects.

SWELLINGS OF THE SCROTUM AND ITS CONTENTS

Differential Diagnosis and Management

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SWELLINGS of the scrotum and its contents are of interest and importance because of their relatively frequent occurrence and because a serious condition often may be overlooked or erroneously considered trivial in nature. In spite of the fact that these swellings are easily accessible to the patients, a lesion may progress unnoticed and untreated until it menaces not only the patient's health but also his life. On the other hand, it is true that most such swellings are benign in character, and part of the physician's duty in such a case is to reassure the overly apprehensive patient.

Since most patients with any genital abnormality initially consult the family physician or surgeon, it is essential that he know the diagnostic possibilities and correct management. Diagnosis of these testicular and scrotal masses depends primarily on the history and physical findings rather than on laboratory aids. This should serve as a challenge to the alert and conscientious clinician.

In this paper we shall approach the problem first by discussing briefly the commoner lesions as we have encountered them, emphasizing the pertinent points in the history and physical examination and indicated laboratory procedures. Finally, we shall touch on the treatment and management of the rarer but graver intrascrotal masses.

COMMONER LESIONS

Scrotal Hernia.—Hernia must be considered well up on the list of scrotal swellings. Scrotal hernias as we have observed them are found chiefly in elderly men or in infants and children in whom they are congenital, originating with failure of obliteration of the processus vaginalis. An associated hydrocele is often present in the young. An experienced examiner ordinarily has no difficulty in diagnosing typical scrotal hernia.

If the presumed hernial mass is irreducible, however, and does not transilluminate, the physician must immediately consider incarceration or strangulation of the hernial sac contents or he must recognize that the mass is not a hernia at all but may well be a testicular tumor, torsion, or hematocele. Resolving the diagnostic quandary by prompt surgery is to the patient's advantage.

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Read before the Section on Surgery, Texas Medical Association, Annual Session, Dallas, May 6, 1952.

Hydrocele.—The congenital type of hydrocele associated with hernia has just been mentioned. Characteristically a hydrocele is simply an accumulation of fluid in the serosal sac (tunica vaginalis) which invests the testicle. The quantity of fluid may vary from a few centimeters to a liter or more. Although a small hydrocele may accompany an epididymitis or tumor, the ordinary variety is idiopathic in origin, there being no discernible cause except in the developmental congenital form.

The swelling due to a hydrocele is not tender, painful, nor reducible and causes symptoms simply by its weight and size. On examination the most important physical finding is transillumination of the contents when a light is held behind the tense cystic mass.

The most satisfactory treatment of hydrocele consists in surgical excision of the excess tunica vaginalis with suture of the everted serosal margins behind the testis and cord. Removal of the straw-colored fluid by tapping with a large needle is a useful diagnostic measure but is invariably followed by re-accumulation within a comparatively short time and is not definitive therapy. Injection of sclerosing fluids has little to recommend it and is reserved for those patients who refuse surgery.

If there is any possibility of an associated hernia, particularly in a child, the operative incision should be made high over the inguinal canal in order to repair the hernia through the same approach. Cotton suture material and nondrainage are recommended in children. In an adult, if the presence of a hydrocele alone is certain, an incision on the anterior aspect of the scrotum is preferred. In the massive hydrocele or where bleeding is troublesome, a rubber dam drain for forty-eight hours and compression dressing will prevent postoperative swelling and hematoma formation. Catgut suture material is advocated in the hydrocelectomy in adults.

Epididymitis.—Inflammatory lesions of the epididymis may be acute or chronic. The acute form is characterized by severe pain and tenderness and swelling of the epididymis proper which can be palpated posterior to the testis. The inflammatory process may extend along the cord. The pain often is referred as far distant as the loin. Chills, fever, and systemic signs of infection are accompanying features. Etiologic factors are gonorrhea or a virulent organism from the prostate or bladder descending retrograde via the vas.

Urethral instrumentation and the straining associated with prostatic obstruction are predisposing factors in the nonspecific type. The acute form tends to pass over to the chronic variety with residual swelling and induration of the epididymis. Acute exacerbations are common following sexual activity or severe physical exertion.

Typical acute epididymitis is easy to diagnose by history and physical examination and should be treated conservatively by scrotal support, hot or cold applications, bed rest, and chemotherapy and/or antibiotic agents. Although torsion of the testis (to be defined later) is a rare disease, it closely resembles acute epididymitis, and in questionable cases, immediate exploration should be done to preserve the testicle. Chronic or recurrent epididymitis is best treated by epididymectomy if the condition persists after predisposing posterior urethral factors have been removed.

The tuberculous variety of epididymitis consists of hard, nodular nontender areas within the organ with thickening or beading of the vas. Adherence of the overlying skin and fistula formation are other diagnostic features in long standing cases. Other foci of tuberculosis practically always are demonstrable in the genitourinary tract or in the lungs. In a case of epididymitis suspected to be of tuberculous origin, the physician should check the lungs and kidneys, and then carry out epididymectomy with preservation of the testis unless one of the other systems requires priority of treatment. Extension from the epididymis to the testis itself occurs only in neglected cases. Prophylactic contralateral vasectomy should be considered since the process tends to involve the other side in time. Epididymectomy should be followed by the customary supportive therapy and streptomycin administration.

Orchitis.—The diagnosis of "orchitis" is made much more frequently than it actually occurs. Except for the acute orchitis of mumps, infection of the testis proper is a rare condition. Most cases so diagnosed are actually epididymitis. On the other hand, orchitis associated with mumps is common after puberty. The typical picture is that of an acutely painful swollen testicle developing a few days following the onset of parotitis with high fever, prostration, and pain in the groin. Rarely the testicular swelling precedes the parotid swelling. In an appreciable percentage of cases bilateral involvement is found. In spite of the many proposed treatments, we have found that nothing affects the course of the disease, which runs a self-limited course. Chemotherapy, antibiotic drugs, stilbestrol, and serum from convalescent patients have been tried with questionable benefit. Surgical incision of the tunica albuginea has been recommended by some and condemned by others. The patient with mumps orchitis should be told that his potency will be preserved but that he will in all likelihood be sterile on the involved side.

"Traumatic" orchitis with hematocele typically follows a direct blow to the organ. Bed rest, elevation, and ice usually suffice in treatment, but if relief of pain and swelling is not obtained promptly, surgical drainage of the tunica vaginalis and direct inspection of the testis may shorten the convalescence as well as preserve the testis from atrophy. It has rarely been necessary in our experience.

Spermatocele.—A common innocuous lesion is the spermatocele which represents a retention cyst of the vas efferentia (the tubules connecting the epididymis to the testicle). These cysts may vary from pea size to one containing an ounce or so of milky opalescent fluid teeming with spermatozoa on microscopic examination of the aspirated material. Except for their presence, spermatoceles cause no significant symptoms and require no treatment unless a question of diagnosis arises or the size of the mass is an inconvenience. Surgical excision of the cyst and sometimes partial epididymectomy is the treatment of choice if exploration is decided upon.

Varicocele.—The common varicocele presents no problem in diagnosis. The characteristic "wormlike" feel of the distended elongated tortuous veins in the pampiniform plexus on the left side is familiar to all physicians. Exaggeration of the mass on straining or standing and disappearance on recumbency are features to be noted. Varicocele is usually asymptomatic and causes no damage to the testicle. When there is question of beginning testicular atrophy from the stasis or when the physician is convinced of bonafide symptoms in a stable patient, operation may be carried out with satisfactory results. The most physiologic operation is the excision of a segment of the internal spermatic vein through an inguinal incision and suspension of the low hanging testicle. In most instances, however, a simple suspensory will suffice. The physician should beware of surgery for varicocele in the confirmed hypochondriac or sexual neurotic.

RARER LESIONS

Torsion of Testis.—Torsion of the testis or, more properly, torsion of the spermatic cord depends upon a rotation of the abnormally mobile testicle within the tunica vaginalis. This anatomic abnormality has been described as the "bell clapper" deformity. The factor of unusual physical exertion is thought to initiate torsion although cases have been reported as occurring while the patient was at rest or even asleep, in which instances cremasteric muscle contractions have been postulated. The clinical picture consists of

the sudden onset of testicular swelling and pain of shocking severity. On examination the testicle tends to be retracted upward, is tender with the overlying skin becoming edematous early. Distinction on palpation between the testis and epididymis is soon lost and cannot be made out as it can in epididymitis. Later the pain subsides but the tenderness and swelling persist.

This course of events reflects a vascular catastrophy to the testicle. It is readily apparent that treatment of a suspected torsion must be immediate exploration with untwisting of the constricted vessels before thrombosis and infarction occur if the testis is to be saved. At the time of surgery the physician must decide if the testicle is viable or not. Orchidectomy is unavoidable when obvious infarction is present. Return of circulation on detorsion is evident within a matter of minutes, and in such instances, anchoring the testicle to the scrotal wall is the proper surgical treatment.

Since in the literature there are a number of reports of bilateral torsion, the predisposing anatomic defective fixation of the testis may be presumed to be bilateral in an appreciable number of cases. For this reason prophylactic orchidopexy on the side opposite to the torsion may logically be recommended, particularly if prior orchidectomy of the mate were necessary. A simple "bottle operation" with fixation suture to the scrotal wall suffices.

In differential diagnosis, the syndrome of torsion may be confused with acute epididymitis or incarcerated hernia. Some observations pointing toward torsion are the suddenness of onset and edema of scrotal tissues in a previously normal patient.

Tumor of Testis.— Although comparatively rare, malignancies of the testicle comprise the most important group of intrascrotal swellings because of the inevitable fatal outcome unless properly handled. The peak incidence of neoplasms of the testicle occurs in the third and fourth decades but is not unknown in older persons. It is rare before puberty. The incidence in the Armed Forces where a series of more than 900 cases were observed was 1 in 10,000 patients. No characteristic picture is present other than a painless nontender swelling of the testis. Even though the patient attributes the swelling to a recent trauma in a good proportion of cases, it is improbable that the injury did more than call his attention to a preexisting lesion. The degree of anaplasia varies with the morphologic type; nevertheless, all testicular tumors should be regarded as highly malignant. The rate of growth and size are variable factors.

Diagnosis is principally a matter of exclusion. Unless the physical findings unequivocally point to another lesion such as epididymitis or hydrocele, the presumptive diagnosis should be neoplasm until disproved. Occasionally a mass of retroperitoneal lymph nodes or "cannon ball" shadows in the chest roentgenogram will be the earliest manifestation of testicular tumor. Routine chest roentgenograms and excretory urograms are indicated in testicular tumors to give information regarding retroperitoneal or mediastinal node involvement. Another diagnostic procedure in suspected cases is the employment of the Aschheim-Zondek test for gonadotrophic hormone. This test is of confirmatory value if positive, but if negative, malignancy is not excluded. Whereas aspiration of a hydrocele to permit more accurate palpation of a "suspicious-feeling" testis is good practice, "needle biopsy" of a testicular tumor itself has no practical advantages and considerable theoretical disadvantages in our opinion.

For practical purposes, therefore, immediate surgical attack on any lesion suspected to be a tumor is the safest rule. When diagnosis is reasonably certain, approach through an inguinoscrotal incision with complete removal of cord and testicle from the internal ring downward is preferred. Where reasonable doubt is present, opening of the tunica vaginalis through a scrotal incision and direct inspection is indicated. If, after this, doubt still exists, a rubber shod clamp should be applied to the cord above the testicle to avoid tumor embolization and a biopsy specimen taken. This is rarely necessary as the gross appearance and "feel" usually are unmistakable.

The operation of radical retroperitoneal lymph node dissection is also being carried out by some surgeons after the orchidectomy. As soon as the microscopic pathologic report confirms the diagnosis of malignancy, radiologic therapy in cancerocidal dosage to the retroperitoneal regional lymph nodes should be carried out by a radiologist skilled and interested in roentgen therapy. Many testicular tumor cell types such as the seminoma are radiosensitive, and routine irradiation treatment to the lymph drainage areas greatly increases the "cure" rate. Whether the results of retroperitoneal lymph node dissection will be better than by combined orchidectomy and roentgen-ray therapy has not yet been determined. The procedure would appear theoretically preferable where the original lesion is radioresistant—such as in the embryonal carcinomas and teratocarcinomas.

Miscellaneous.— Some causes of swelling of the scrotum which involve the skin and subcutaneous tissues should be mentioned. Edema of right-sided heart failure or hypoproteinemia associated with chronic liver disease or malnutrition may first be detected in the scrotal tissues. Allergic phenomena such as angioneurotic edema, insect bites, and contact dermatitis usually are easily recognized. Lymphedema from nontropical elephantiasis and lymphopathia venereum are self-evident.

SUMMARY AND CONCLUSIONS

Scrotal masses are discussed from the viewpoint that serious lesions are still too frequently overlooked, regarded as insignificant, or erroneously considered benign. A differential diagnosis depends on the history and physical examination rather than on elaborate special tests. When the diagnosis is at all questionable, early surgical exploration is advocated as preferable to "watching" the lesion. Furthermore, some scrotal swellings represent surgical emergencies, for example, torsion of the testicle.

ABSTRACT OF DISCUSSION

DR. JASPER H. ARNOLD, Houston: In the differential diagnosis of scrotal swellings in the miscellaneous category, I would add extravasation of urine, which may be a surgical emergency with scrotal swelling as the presenting symptom. This condition may be seen in men with urethral strictures or in patients following so-called straddle injuries. I would also add extensions of septic processes from periurethral inflammations and perirectal involvements. Each of these conditions may need extensive surgical drainage and may involve the scrotum. Emphysematous swelling of the scrotum may occur as a primary entity when invasion is due to gas-forming organisms, and emphysema is not unknown when, after the closure of an incision for kidney surgery, air incarcerated in the dead space in the wound works itself retroperitoneally to confuse the surgeon by presenting in the scrotum.

Testicular tumor is a grave and serious but albeit a rare disease. Our most up-to-date and useful knowledge on this subject comes from Dr. R. A. Moore of St. Louis, who has reviewed about 1,500 of these tumors in the Army Institute of Pathology. The Army is the most prolific source of these tumors as the optimal age incidence of this disease coincides with the average age span for Army service generally. Ninety-six per cent of testicular tumors fall into four groups, named in order of their malignancy: chorioepithelioma, embryonal carcinoma, seminoma, and adult teratoma. These cellular types occur together and in combination. The seminoma occurs in pure type more often than the others. It is sensitive to roentgen ray, and with adequate treatment as described by Drs. Spence and Shannon carries a five year survival rate of from 60 to 80 per cent. The embryonal carcinoma, with adequate treatment, carries a five year survival rate of from 20 to 35 per cent. Moore says that the five year survival rate of chorioepithelioma is zero. The adult teratoma, when pure, is a benign tumor.

Another condition the essayists describe, epididymitis, in my experience, is too frequently diagnosed erroneously as orchitis. Orchitis is a rare disease, epididymitis is common. I would like to discuss briefly the etiology and implications of an attack of epididymitis. Because gonorrheal complications are now so rare, I will confine my remarks to epididymitis of so-called nonspecific origin. Usually this condition is, in reality, only one manifestation of a more important if less dramatic syndrome, acute or chronic prostatoseminal vesiculitis. Hematogenous infections of the epididymis may occur, but rarely. Inflammation of the epididymis is most commonly due to bacterial infection forced retrograde through the vas deferens, and this condition is the most frequent cause of scrotal swellings. Any such infection of the epididymis depends entirely on a previous infection above, in the seminal vesicle, ampulla, prostate, urethra, or bladder, or all of these. It is a signal advising of this deeper and more significant condition and should direct attention to the organs just mentioned. Epididymitis, as Drs. Spence and Shannon point out, may be acute or chronic, depending somewhat on the condition of the organs above, on bacterial virulence, and on body immune response. Considering the many men who have prostatoseminal vesiculitis, it is rather surprising that more do not have epididymitis. Usually with acute epididymitis, but even with the chronic type, the patient will describe, as occurring a day or so before onset, an episode of trauma, excessive muscular activity, or straining in which he suddenly contracted the diaphragm and abdominal muscles, and with a powerful expiratory grunt greatly raised intraabdominal pressure. The bladder, prostate, ampulla of the vas, posterior urethra, and seminal vesicles, lying as they do at the bottom of the pelvis, receive this pressure much as a bellows is compressed, and acting against the tight external urethral sphincter and/or edematous ejaculatory ducts, infected material is forced retrograde through the vas and into the minute tubules of the epididymis, setting up the infection there.

When epididymitis is treated correctly in other ways, surgical drainage is seldom necessary. The gram-negative bacillus is nearly always present in cultures of these infections, and therefore penicillin, being ineffective against organisms of this class, must be augmented by other chemotherapeutic or antibiotic agents capable of inhibiting whatever strain of gram-negative bacillus is present. To arrive at this information, culture of the prostatoseminal vesicle secretion and the urine, combined with careful antibiotic sensitivity tests made on these cultures, may be of great value. Dr. Spence and Dr. Shannon mention the other adjuncts to therapy. Later, epididymectomy may be necessary in chronic cases, but epididymectomy does not, of course, cure or relieve the prostatoseminal vesiculitis which may exist above and which, if neglected, may wholly or partially incapacitate the patient at some later date. Therefore, let us heed the signal of an epididymitis, even when ever-so-mild, and look for and treat this deeper disease.

DR. MICHAEL K. O'HEERON, Houston: I would like to emphasize a point concerning the treatment of neoplasms of the testicle advocating radical surgery in certain types of testicular tumors. In the case of seminomas, statistics show that between 50 and 60 per cent of all patients are cured by treating them with simple orchidectomy followed by deep roentgen-ray therapy. So we are hardly justified in subjecting these patients to radical surgery in an attempt to improve these statistics.

In the case of the embryonal carcinomas, teratomas, and possibly the chorioepitheliomas, the picture is different. The survival rate is considerably lower and the response to irradiation therapy is poor, especially in the embryonal carcinomas and the teratomas. If we are to offer this group of patients a chance of survival, it is necessary that we resort to extremely radical surgery as early as possible.

Recently I have become interested in the thoraco-abdominal approach to the retroperitoneal space as advocated by Chute and his associates in Boston. This approach gives excellent exposure to the retroperitoneal space and it enables one to interrupt the lymphatic channels at the level of the diaphragm before handling them more distally. Following this initial interruption of the lymphatic channels, it is easier, because of the increased exposure, to dissect out all of the retroperitoneal lymphatics. This radical approach should be considered in an attempt to increase the chances of survival of these unfortunate patients.

PULMONARY HISTOPLASMOSIS

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HISTOPLASMOSIS might be termed a disease of the twentieth century since only within the past fifty years has it been recognized as a disease entity. Our knowledge of it begins in 1905 when Samuel T. Darling, a pathologist in the Panama Canal Zone, described the organism which he found in a native who had died of high fever, vomiting, and a mental disturbance. He described the organism as being round or oviform with a capsule. He noted that the organism was always found to be intracellular and was amazed that one cell contained three hundred organisms! He thought the disease was related somehow to leishmaniasis and that the organism he had found was a protozoan. He named it Histoplasma capsulatum.[4] Following this initial discovery there is a long hiatus in the history of the disease until 1926, when Watson and Riley reported a case of active disseminated histoplasmosis in Minnesota. The exact nature of the organism was not known until 1933, when DeMonbreun, a bacteriologist, grew it from the lymph node of a child who died of the disseminated form of the disease.[7] He proved it to be a fungus that had a yeastlike form in the reticuloendothelial cells of the body. Upon growth in culture media outside the body it formed mycelia. Within the past fifteen years there has been a marked interest in the roentgen-ray finding of disseminated pulmonary calcification. Many of these patients do not react to tuberculin or coccidioidin but do react to histoplasmin. This has focused more attention upon histoplasmosis though it would appear from what we know about it that many of the final data remain to be gathered and classified.

EPIDEMIOLOGY

As interest in pulmonary calcification has increased, so has knowledge of the extent of pulmonary histoplasmosis. Originally an attempt to relate pulmonary calcification to infestation by Ascaris was attempted but failed. Aaronson and his co-workers proved that many of these calcifications were related to positive coccidioidin skin tests.[12] It remained for Christie, Peterson, and Palmer to note a high incidence of positive histoplasmin skin tests and pulmonary calcification in residents of the east-central United States. Long and Stearns also showed a high incidence of pulmonary calcification in inductees from the east-central United States. Charles E. Smith noted the presence of pulmonary calcification in residents of the Ohio River basin who reacted to histoplasmin.[3] Active histoplasmosis has been found in persons from twenty-five states (Kentucky, Arkansas, Illinois, Iowa, Indiana, Maryland, Mississippi, Missouri, North Carolina, Ohio, Tennessee, Virginia, West Virginia, Minnesota, California, Wisconsin, Michigan, Florida, Alabama, Nebraska, Texas, Louisiana, New York, Kansas, and Oklahoma) and Washington, D. C. (fig. 1) and seventeen foreign countries.[8, 9, 13]

Furcolow has done a great deal of skin testing among Kansas City school children and has estimated that 80 per cent of the people tested in the Kansas area are positive to histoplasmin. In the Kansas survey of 60,000 people there were 174 cases of disseminated pulmonary calcification. Out of these 1 patient reacted to tuberculin and 149 to histoplasmin alone. Three persons reacted to neither histoplasmin nor tuberculin and 21 reacted to both. Therefore, approximately 98 per cent of those people with disseminated calcification reacted to histoplasmin and only 13 per cent to tuberculin. As a result of this survey and others with similar results, it has been postulated that when disseminated pulmonary calcification is found, its origin is more likely to be histoplasmosis than any other disease. In those areas in which skin testing has been done, particularly Kansas City, there is a greater frequency of positive histoplasmin skin tests in white persons (4.5 per 1,000) than in Negroes (1.2 per 1,000).[6] Of the reviewed cases of active disease the range of age has been from 7½ weeks to 77 years.

Little is known about the early stages of the disease, although it is thought that probably there are two portals of entry. Since pulmonary calcification plays such an important part in our contact with the disease, it is thought that the respiratory tract is the most frequent portal of entry. Also since persons with histoplasmosis have lesions around the nose, mouth, and tongue, the gastrointestinal tract probably represents the second portal of entry. The source of infection for man is not known. In trapped animals the fungus has been found in the dog, mouse, cat, rat, and skunk. Cows in the Kansas area have positive skin tests but to no greater degree than in man so that they are probably not a reservoir for the disease. Soil studies in Kansas and Maryland have revealed the fungus, and epidemiologists believe the soil and the cat serve as principal sources of infection.[13]

ORGANISM

As has been mentioned previously, the responsible organism has been named Histoplasma capsulatum and is a fungus. Budding yeastlike forms are usually

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found in the macrophages and reticuloendothelial cells in the body. They vary from 1 to 5 microns in diameter and are surrounded by a thick membrane with one or more fat deposits and usually a single protoplasmic granule present.[10] The organism will grow the mycelia form on the usual Sabouraud's media at room temperature within two to four weeks. Good results have been obtained by growth on blood agar at 37 C. In suspected cases material may be injected into a rat or mouse. At a later date the fungus can be found disseminated throughout the body of the inoculated animal but especially in the spleen and liver, where the reticuloendothelial system is most abundant.[6] Figure 2 shows numerous organisms in a granulomatous area in the kidney of a patient who died of disseminated histoplasmosis.

PATHOLOGY

As an indication of the primary pathologic disturbance in this disease, histoplasmosis has been called reticuloendothelial cytomycosis. Since the reticuloendothelial system is found in all organs of the body, the organism may be found in all organs of the body. However, it is most frequently observed in the spleen, lymph nodes, liver, and gastrointestinal tract. In the lung it may be found interstitially or in the large macrophages in the alveoli. In the lungs the histologic appearance is a mixture of necrosis, exudation, and proliferation. Rarely liquefaction takes place so that cavitation is extremely unusual in the pulmonary form of histoplasmosis. The liver will contain areas of necrosis and granuloma and the spleen and the lymph nodes will have their sinusoids filled with the organisms. Blood vessels will be filled with macrophages containing the organisms. The gastrointestinal tract beginning at the tongue and ending with the rectum may contain ulcerations with a granulomatous base. The mesenteric lymph nodes are nearly always involved and the adrenal glands also are frequently involved. The kidneys show granulomatous lesions. Endocarditis has been reported.[10] An interesting study was done in reexamination of appendices that had been removed from children. There were 436 which had been diagnosed as normal, chronically inflamed appendices or showing lymphoid hyperplasia. Out of these, 54 were found to contain organisms resembling Histoplasma capsulatum.[14]

When the lungs are involved, early symptoms may be cough, chest pain, cyanosis, and shortness of breath. In those patients who are acutely ill with active pneumonic disease, the usual finding is consolidation or infiltration. Terminally, there may be signs of bronchopneumonia. Frequently in children the diagnosis of whooping cough is made, although if there is fever one should suspect histoplasmosis.[10] In pulmonary lesions the usual symptoms are fever, weight loss, cough, weakness, dyspnea, chills, sweats, chest pain, expectoration, hoarseness, hemoptysis, and cyanosis. Other signs and symptoms may refer to other areas of involvement, such as rectal hemorrhage, arthritis, chills, weight loss, abdominal pain, enlarged liver and spleen, or enlarged lymph nodes. The skin may contain purpura, granulomas, ulcerations, abscesses, nod-

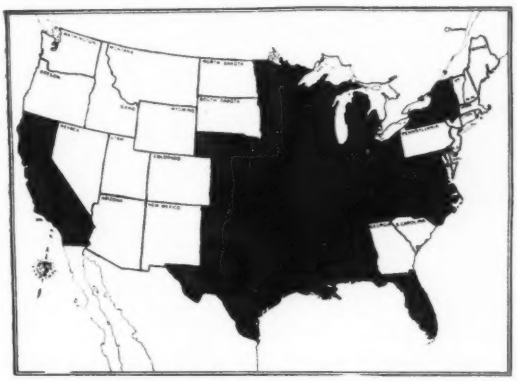

FIG. 1. Map of the United States in which shaded areas indicate where cases of active histoplasmosis have been reported.

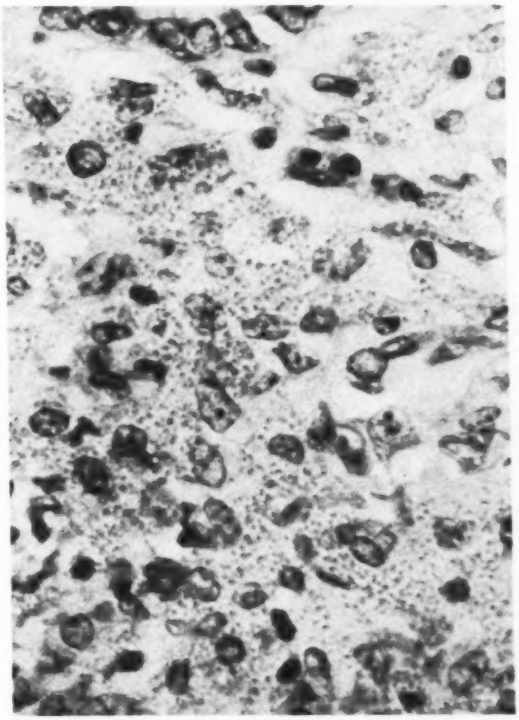

FIG. 2. Granulomatous lesion in kidney showing numerous Histoplasma capsulatum.

ules, or papulonecrotic lesions.[8] In those cases in which the patient is asymptomatic and pulmonary calcification has been the only manifestation, there will be no abnormal physical findings.

DIAGNOSIS

The differential diagnosis of disseminated histoplasmosis includes tuberculosis, carcinoma, Hodgkin's disease, leukemia, and possibly other fungus diseases. If one suspects that histoplasmosis is the cause of an illness, attempts should be made to grow the organism from sputum, blood, marrow, biopsy specimen, or gastric aspirations.[5] As was mentioned previously, rat or mice inoculations also may grow the suspected organism. The skin test is similar to the tuberculin test. The material is taken from a culture of the fungus and diluted 1:1,000. Of this 0.1 cc. is injected intradermally and read in forty-eight to seventy-two hours. A positive test is one in which an area with a diameter of 5 mm. or more of induration results. Skin tests are important but a positive reaction may be delayed up to four months after onset of the disease.[10] A histoplasmin patch test has been devised but has not been found to be practical.[15] In many cases in the literature the skin tests and complement-fixation were negative during the course of the illness and the diagnosis was made only at autopsy. It is also of interest that, similar to the tuberculin skin test, the histoplasmin skin test may be depressed during a severe and debilitating illness.

Evidence in roentgenograms of the chest varies in active pulmonary histoplasmosis. There may be bronchopneumonia with scattered infiltrations, consolidation of a lobe or a segment of a lobe, cavitation, contraction, pleurisy, or nodular densities. Actually the appearance of the lungs is not specific.[1] Cavities are extremely unusual because the granulomatous lesions do not liquify easily. In asymptomatic pulmonary histoplasmosis with disseminated calcification, the radiologic appearance is extremely interesting. There are two general types described: one in which the calcified densities are small, round, uniform, numerous, symmetrical, and widely spread resembling healed hematogenous tuberculosis or "buckshot," and the other group in which the calcified deposits are fewer, irregularly outlined, of varying size, and distributed asymmetrically. Theoretically, this second group corresponds to a bronchogenic spread of the disease.

FIG. 3. Left. Chest roentgenogram of the patient in case 1 showing "hematogenous" or "buckshot" distribution of calcified densities of histoplasmosis origin.

Right. Chest roentgenogram of the patient in case 2 showing the "bronchogenic" distribution of calcified densities of histoplasmosis origin.

CASE 1.—Figure 3 *left* demonstrates the first type. It is the chest roentgenogram of W. S., a 46 year old white, male, laborer. He has no family or contact history of tuberculosis. There is a history of a severe respiratory infection between 1920 and 1930. He was inducted into the Army in 1940 but no chest roentgenogram was made. In November, 1941, he applied for an Army discharge because he was over age. Roentgenograms of his chest showed the numerous tiny calcified densities. No skin tests were made. Sputum studies were negative. He was discharged as having healed miliary tuberculosis. He was reexamined in May, 1951 (fig. 3 *left*). He had no symptoms and physical examination of the chest was normal. Skin tests for tuberculosis, blastomycosis, and coccidioidomycosis were negative. A histoplasmin skin test was positive.

CASE 2.—Figure 3 *right* is the chest roentgenogram of F. L., a 21 year old white stenographer. Her past history revealed that she had had pneumonia at the age of 8. She also had frequent respiratory infections, characterized by a watery nasal secretion, sore throat, and a cough productive of thick mucopurulent material. During one of these periods of infection she was hospitalized briefly and the roentgenogram (fig. 3 right) showed the calcified densities of varying size, irregularly spaced, few in number, and distributed asymmetrically. Calcium also was present in the hilar lymph nodes. She was seen by me in 1951 during one of her bouts of respiratory infection. Physical findings and laboratory studies were not unusual, but a skin test for histoplasmin was positive, while those for tuberculin, blastomycin, and coccidioidin were negative. This patient represents a case of healed, calcified histoplasmosis of the "bronchogenic" type. Her hilar lymph nodes also are involved.

Subgrouping of the disease depends upon whether hilar calcification involving hilar lymph nodes is present.[5] When there are widespread bone lesions, there will be radiolucency due to the granulomatous lesion with an associated periosteal reaction.[10]

Laboratory findings on patients with active histoplasmosis are varied but tend to follow some pattern. Usually an anemia is present and most frequently patients have a leukopenia. If a leukocytosis is found, later examination of the white blood cells will show a leukopenia occurring sometime during the course of the disease. Usually normal platelets are noted.[16] The complement-fixation test may be one of two types. In the first the antigen is prepared from the yeast phase of growth and in the second histoplasmin skin testing material is used. The test must be strongly positive (++++) to be considered diagnostic. The test will be negative in the healed form of the disease. There is no correlation between the skin test and serologic tests. As is true with the majority of such tests, a change in titer is important in making a diagnosis. A positive test of low titer is considered to be a poor prognosis.[10]

TREATMENT

As of this moment there appears to be no satisfactory agent in the treatment of histoplasmosis. Among those used without success are Promin, actidione, penicillin, streptomycin, Aureomycin, Chloromycetin, sulfonamides, arsphenamine, Stilbamidine, Pentnucleotide, roentgen ray, sodium thiosulfate, iodides, vaccines, blood transfusions, Atabrine, and ultraviolet ray.[11] More recently Christie and his co-workers have reported the use of ethyl vanillate. This is the ethyl ester of vanillic acid, which was found to be fungicidal for organisms which caused food spoilage during the war. Its formula is $C_{10}H_{12}O_4$ and it resembles the phenols in reaction. It can be given in 40 per cent solution of olive oil to children and by capsules to adults. The usual dose is 1.5 Gm. per kilogram of body weight per day, which is begun in dosage of 0.5 Gm. per kilogram per day and increased every five days by 0.5 Gm. until 1.5 Gm. is reached. One must give a six weeks' course of the drug to achieve results. Actually the margin between therapeutic effect and toxicity is narrow. Signs of toxicity include drowsiness, apathy, inactivity, drug fever, and respiratory alkalosis. Christie treated 12 infants and 5 of these survived, presumably due to the effects of the ethyl vanillate.[2]

ANALOGY TO TUBERCULOSIS

Throughout this discussion I frequently have alluded to the marked similarity between the disease process of histoplasmosis and that of tuberculosis. Both are diseases which can affect any system of the body but to which attention has been called primarily through pulmonary manifestations. In both instances physicians depend upon skin tests and the finding of the organism for positive diagnosis. The skin test may not become positive until late in the disease, and in both, the skin tests may become negative if the patient is overwhelmingly ill or if an intercurrent disease intervenes. The diseases may be found incidental to routine surgery such as removal of the appendix or tonsils. The pulmonary manifestations such as cavitation, empyema, pleuritis, consolidation, and the various radiographic appearances are similar. The radiographic appearance in both diseases suggests a bronchogenic form of spread as well as a hematogenous form of the disease. The portal of entry in both diseases is suggested to be mainly pulmonary, but occasionally oral. The pathologic change in both diseases is a mixture of necrosis, exudation, and proliferation and suggests a granulomatous process.

SUMMARY

Certain facts about pulmonary histoplasmosis are presented. History, epidemiology, causative organism, pathology, differential diagnosis, and treatment are discussed. Its similarity to tuberculosis is emphasized, but its concept as a recently recognized disease is also stressed.

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Physiologic Basis and Clinical Application of Some Tests of Liver Function

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THE differential diagnosis of the jaundiced patient has for years intrigued the practicing physician. A benign type of jaundice has been recognized for a number of years and described under various terms. The outbreak of infectious hepatitis and the epidemic and recognition of homologous serum hepatitis during World War II has led to more detailed studies of liver function and has emphasized the necessity of arriving at an accurate diagnosis in a patient who presents himself with jaundice. Generally speaking the diagnostic goal should be to differentiate those patients who should be treated surgically from those who should be treated medically. Because of the vast number of different functions of the liver and because of the liver's tremendous physiologic reserve, countless tests have been devised to study various phases of liver function. This discussion will attempt to classify these tests upon some physiologic basis and to give a better insight into the correct selection of tests and their interpretation in a variety of conditions.

It would be well to outline the normal physiology of bilirubin excretion. Three body systems are involved in this process: the reticuloendothelial system, the parenchymal cells of the liver, and the gastrointestinal tract. Bilirubin has its origin from hemoglobin, being converted in the reticuloendothelial system through verdohemoglobin, an iron-biliverdin-globin complex, to biliverdin-globin from which the iron has been freed, and finally to a bilirubin-globin complex. This is the indirect acting bilirubin which is found in the serum by van den Bergh's reaction. As this bilirubin-globin complex is passed through the liver cell, the globin is separated. Free bilirubin is then excreted into the gastrointestinal tract. This is direct acting bilirubin. Within the intestinal tract bilirubin is converted to urobilinogen, which is simply a mixture of mesobilirubinogen and stercobilinogen. Further, within the gastrointestinal tract some of the urobilinogen is changed to urobilin.

TYPES OF JAUNDICE

Some classification of jaundice should be attempted, and that of Rich[4] is suggested. In this classification jaundice is divided into two main types. The first is retention jaundice, which is characterized by an increase in the bilirubin-globin complex in the blood. This is probably never pure in nature, since a normally functioning liver in all probability can handle any amount of bilirubin-globin complex which will be brought to it under any conditions of hemolysis. This type of jaundice occurs characteristically in hemolytic anemias either congenital or acquired, in which instance the diagnosis is made by the other features of the hemolytic process.

The second large group of jaundice in Rich's classification is regurgitation jaundice, which is characterized by an increase in bilirubin and other substances of the bile in the blood. This regurgitation may have its origin from either intrahepatic or extrahepatic disease. In intrahepatic disease the liver cells and bile capillaries may be the primary site of disease with regurgitation taking place at that level. In this instance there will be evidences of parenchymal cell damage. On the other hand, the cholangioles themselves may be the primary site of difficulty in which case there will be evidences of cholangiolar damage as indicated by tests of liver function. Finally the disease may have its origin in the extrahepatic biliary system as from obstructions of the common bile duct either from within the bile duct or from outside the bile duct.

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LIVER FUNCTION TESTS

At this point it would seem well to attempt to classify some of the commonly used tests of liver function upon the basis of the specific function for which they test.

Hepatocellular Function Tests.—Let us first consider those tests which primarily have to do with hepatocellular function. There is a group of these tests which depend upon the disturbed protein metabolism which accompanies disease of the liver. The ones I have chosen to discuss are the cephalin cholesterol flocculation test of Hanger[1] and the thymol turbidity test of Maclagan.[3] Both of these tests depend either upon abnormal protein circulating in the serum or upon abnormal quantities of a normal protein. Since organs other than the liver are involved in protein metabolism, it becomes apparent that neither of these tests is specific for liver disease although they may well be indicative of deranged hepatic function.

The second test which has to do primarily with hepatocellular function is the bromsulfalein test. This test depends upon the measurement of the amount of a foreign substance, excreted by the liver, which remains in the serum after a measured period of time. We have found that 5 mg. of the dye per kilogram of body weight is the most desirable dose, and the time interval which seems most reliable is forty-five minutes. With this dose and at this time interval less than 3 per cent retention of the dye should be found in the presence of normal liver function.

The third test which has to do with hepatocellular function is measurement of the amount of urobilinogen in the urine. This will be mentioned in somewhat more detail later, but it should be listed here as being indicative of liver cell function.

Finally a useful test in certain situations is the response of prothrombin activity to the parenteral administration of vitamin K. Prothrombin is formed in the liver and depends for its formation upon the presence of vitamin K. Whether a prothrombin deficit results from inability of the liver cells to produce prothrombin or from a deficiency of vitamin K is always questionable in any given case. However, in the face of normal liver cell function a small intravenous dose of vitamin K, usually in the amount of 4 mg., should result in a normal prothrombin level within twenty-four hours.

Hepatocanalicular Function Tests.—There are two tests of liver function commonly used which deal primarily with the functions of the bile canaliculi. These are the alkaline phosphatase and the total serum cholesterol tests. If the disease is primarily one involving bile canaliculi, the alkaline phosphatase and total serum cholesterol levels will probably be elevated. Certain exceptions to this will be discussed later under specific disease processes.

Nonspecific Tests.—Finally some mixed or nonspecific tests of liver function are worth considering. The first of these tests is a simple determination of the serum bilirubin level in the blood. It is apparent that elevation of serum bilirubin may occur from intrahepatic disease, from disease of the ducts, or even from an overproduction of bilirubin by a hemolytic process. Consequently, although this is a valuable test, there is nothing specific about it.

The second test in this category is the ratio of cholesterol to cholesterol esters. The ratio of esters to total cholesterol is a good index of hepatocellular function. However, since the total cholesterol value may be elevated by obstruction to the bile canaliculi as mentioned previously, this test is somewhat mixed in its specificity.

The third test is determination of the prothrombin time or prothrombin level in the blood. This has already been discussed briefly and depends not only upon adequate function of the liver cells but upon an adequate supply of vitamin K available to the liver. A deficit in vitamin K may result from obstruction to the bile ducts, since vitamin K is not absorbed from the gastrointestinal tract in the absence of bile, or may result from diseases of the gastrointestinal tract characterized by poor intestinal absorption as for example in sprue.

The final test in this mixed or nonspecific group is the presence of bilirubin in the urine (Harrison[2] spot test). This, of course, occurs in any instance where regurgitation jaundice is present, whether it arises from the liver cell or some part of the biliary duct system. Therefore, even though it is always indicative of regurgitation jaundice, it does not go further in localizing the disease process.

Since Watson's[5] method of estimating the amount of urobilinogen in both the urine and the feces makes possible a simple clinical test, it would seem well to discuss briefly the normal physiology of the enterohepatic circulation of urobilinogen. Bilirubin, as such, is excreted by the liver and passes into the gastrointestinal tract. Under normal conditions there are between 200 and 400 mg. per day. Within the gastrointestinal tract the bilirubin is converted largely to urobilinogen, which, as has already been mentioned, is a mixture of various decomposition products of bilirubin. Within the gastrointestinal tract 100 to 200 mg. of urobilinogen per day are reabsorbed and carried by the portal circulation back to the liver. The remaining 100 to 200 mg. of urobilinogen per day are excreted in the stool. That portion of urobilinogen which is returned to the liver, in the presence of normal liver function is removed from the blood stream and presumably re-utilized in hemoglobin synthesis. Any residual of urobilinogen which enters

the systemic circulation is excreted by the kidney (up to 3 mg. per day) and occurs in the urine. It thus becomes apparent that increases in the urine urobilinogen indicate impaired hepatocellular function. Decreased amounts or absence of urobilinogen in the urine are probably of no clinical significance. Increased amounts of urobilinogen in the stool represent an increased blood destruction as evidenced by increased amounts of bilirubin entering the gastrointestinal tract. Decreased amounts of urobilinogen in the stool indicate decreased amounts of bilirubin entering the gastrointestinal tract and result from either obstruction to biliary ducts or to serious, almost total, cessation of hepatic function.

There are one or two clinical points that are well worth mentioning here. Obstruction to the common bile duct by pressure from the outside, as from a neoplasm in the region of the head of the pancreas is almost always complete and permanent obstruction. In such instances the urobilinogen as estimated in the stool for twenty-four hours will remain below 10 Ehrlich units per twenty-four hours. Obstruction to the flow of bile from within the liver, as in acute hepatitis, may be complete and result in amounts of pigment in the neighborhood of 10 Ehrlich units or less per twenty-four hours. However, this is not permanent, and the daily determination of the amount of urobilinogen in the stool will show an increasing amount of pigment usually within five days, although occasional patients will have almost total suppression of bilirubin entering the gastrointestinal tract for as long as three weeks. Likewise, in the presence of a common duct stone the tendency of the duct to dilate and to let bile pass in small quantities usually evidences itself as an incomplete or intermittent type of obstruction. This type of obstruction also occurs in tumors around the ampulla of Vater.

APPLICATION OF TESTS

As these tests are applied to various clinical conditions, one must keep in mind that they are simply aids in diagnosis and that clinical history and physical findings must in all cases be correlated with the laboratory findings in the given case.

MEDICAL CONDITIONS

Infectious Hepatitis.—First we shall consider infectious hepatitis. This is a clinical entity which is familiar to all practitioners. The onset is usually insidious with anorexia, generalized malaise, and low grade fever. There may be vague digestive disturbances and discomfort in the right upper quadrant of the abdomen, particularly after exercise. Pain, however, is not usually a prominent symptom. Following two to five days of this type of distress, jaundice usually becomes apparent. The disease then runs a variable course of from one week to as much as three or four months.

The earliest laboratory finding in the preicteric stage of this disease is an increase in the prompt reacting bilirubin in the serum, the so-called one minute bilirubin. This reaction may be increased significantly above its upper limit of normal of about 0.3 mg. to a level of 0.8 or 0.9 mg. without any significant increase in the total amount of bilirubin present in the serum. Even increases of this small magnitude are reflected by the presence of bilirubin in the urine as tested by Hawkinson's[2] modification of the Harrison test or a similarly sensitive test for bilirubin. In this preicteric stage there is almost invariably an increase in the amount of urobilinogen found in the two hour specimen of urine. The bromsulfalein retention test is likewise positive in the early preicteric stage. The other tests of hepatocellular function that were mentioned do not usually become positive until somewhat later in the disease, usually after jaundice has become apparent. One then expects to find an increase in the thymol turbidity; a lowering of the percentage of cholesterol esters; and, somewhat later, a positive cephalin cholesterol flocculation test. Mention has already been made of what one may expect from following the amount of urobilinogen in both the stool and in the urine. There is likely to be a complete suppression of bile entering the intestine early in the disease leading to acholic stools and low amounts of urobilinogen in the urine. After a variable period of time bile again will be excreted into the gastrointestinal tract, and the amount of pigment in the stool will rise to low normal levels accompanied by a tremendous increase in the amount excreted in the urine. Over the period of convalescence this increased urinary urobilinogen will return to normal levels.

It is well to emphasize that a group of tests are important in making a diagnosis. However, certain of these tests lend themselves better to following the course of the disease than do others. If one selects a single test to use in following the convalescence of the patient with hepatitis, one can best put faith in the amount of urobilinogen excreted in a two hour specimen of the urine. After the patient has cleared of jaundice, the size of the liver has returned to normal, and the urinary urobilinogen in a two hour specimen has returned to normal, it is well to exercise the patient and check for increases in liver size and the amount of urobilinogen excreted in the urine in the two hours immediately following exercise to determine whether or not the patient may resume full activity.

Cirrhosis of Liver.—In cirrhosis of the liver the clinical findings of history and physical examination are extremely helpful. In cirrhosis the pertinent history extends over a longer period of time than in

acute hepatitis and in a high percentage of cases will be associated with a history of alcoholism, and here the feature of ascites becomes prominent. Splenomegaly is much more frequent than in acute hepatitis or in primary disease involving the biliary ducts. When the patient with hepatic cirrhosis becomes jaundiced, the differentiation between acute hepatitis and cirrhosis becomes extremely difficult, and the physician must depend primarily upon the past history. It should be mentioned that the cephalin cholesterol flocculation test is much more uniformly positive in patients with hepatic cirrhosis than in those with acute hepatitis. The fact should also be emphasized that during episodes of hepatic decompensation which are often accompanied by focal areas of hepatic necrosis there may be rather extensive leukocytosis, low grades of fever, and, in some instances, pain which closely resembles that of biliary colic, the so-called pseudocolic of hepatic cirrhosis. No further mention need be made of the tests that one would expect to be positive in this condition. Emphasis should be placed, however, on the tests which will be negative. There will be no increase in alkaline phosphatase nor will there be an increase in total cholesterol.

Cardiac Cirrhosis.—Before passing from the so-called medical jaundice to the surgical jaundice, perhaps I should mention the condition which has been described as cardiac cirrhosis. Chronic passive congestion of the liver can produce abnormalities in most of the tests which deal with hepatocellular function. In general the degrees of abnormality are much less marked than in primary hepatic disease. The liver is large and tender. The edge is not firm and sharp but is usually rounded, and the other evidences of cardiac disease are present so that clinically this should lead to little difficulty in differentiation.

Biliary Obstruction.—Next to consider are those conditions which are manifested by jaundice and in which the primary disease lies within the biliary duct system. Mention already has been made of the tests which become abnormal in the presence of impaired duct function. These are particularly the alkaline phosphatase and the total serum cholesterol determinations. It is worth mentioning that clinical observation has shown that the alkaline phosphatase level may often be normal or only slightly elevated in the presence of complete obstruction to the common bile duct from cancer. This is, of course, an exception to the general finding in obstruction of the common bile duct. If one can see the patient with obstruction to the common bile duct early in the course of the disease, the findings are fairly typical and characteristic. There will be little evidence of hepatocellular dysfunction. The primary abnormalities will be an increased serum bilirubin, bile in the urine, and an increase in the alkaline phosphatase and the total cholesterol. However, many of these patients are not seen early in the disease so that superimposed cholangitis and obstructive damage have produced abnormalities in the tests of hepatocellular function by the time the patients are observed. Here again the clinical history and the physical findings will be extremely helpful. Mention need only be made of the significance of a palpable or visible gallbladder or of the roentgenologic demonstration of stones in the biliary system.

Some discussion has already been given of the value of following the amount of urobilinogen excreted in the stools in these patients over a period of several days. This will lead in most cases to a differential diagnosis between carcinomatous obstruction and obstruction from gallstones. However, this differentiation is not too important since both of these conditions should be treated surgically. In the absence of evidence of metastatic lesion one should not arrive at a diagnosis of carcinoma of the head of the pancreas without definite histologic or other evidence which may be obtained only upon abdominal exploration.

Pericholangiolitic Cirrhosis.—There is one condition which should be discussed in this group of cases because it may be extremely confusing: pericholangiolitic cirrhosis. This disease is characterized by a high grade, long standing jaundice with evidence of dysfunction of the biliary ducts as shown by increased serum cholesterol and alkaline phosphatase levels with minimal changes in the tests which have to do with hepatocellular function. The liver is usually large. The spleen is not enlarged in nearly as many of these patients as in the Laennec's type of cirrhosis, and ascites is an uncommon manifestation. The principal complaint of the patient is usually pruritus. Although an uncommon condition, pericholangitic cirrhosis has been considered in the group of cases classified as surgical jaundice since it is believed that in a great many of these patients obstruction to the common bile duct may be important in the pathogenesis of the disease. Under any condition they are entitled to exploration of the common duct.

CONCLUSION

In the great percentage of jaundiced patients an intelligent use of the tests of liver function which are available, coupled with a critical consideration of the clinical history and the physical findings, will make it possible to separate these cases into two main groups which should be treated either medically or surgically.

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ABSTRACT OF DISCUSSION

DR. GEORGE E. CLARK, JR., Austin: Dr. Hayes has covered the important tests of liver function, and with all he has said, I agree. I have one point to emphasize and one point to add.

Urobilinogen determinations of feces and urine cannot be emphasized too much. With apparent obstruction of bile flow as indicated by clay colored stools, it is unwise to consider that the obstruction is complete on visual inspection alone. Watson* has shown that grossly acholic stools may contain measurable quantities of urobilinogen indicating an incomplete obstruction to the flow of bile.

It is also well to remember that in addition to the absence of urobilinogen in urine during the obstructive phase of infectious hepatitis, it is also possible for urobilinogen to be absent in cases complicated by diarrhea. In such cases there will be insufficient time for reduction or reabsorption. It may also be absent with renal damage and nitrogen retention because urobilinogen may be retained.

I certainly agree with Dr. Hayes that a number of tests should be run, the type and number to depend upon the probable etiology and stage of the disease.

On some occasions, even with a battery of tests, I am sure we all have encountered cases in which differentiation between medical and surgical jaundice is all but impossible and only time solves the problem.

**Watson, C. J.: Medical Progress; Bile Pigments, New England J. Med. 227:665 (Oct. 29), 705 (Nov. 5) 1942.*

CASE REPORTS

BAGASSE DISEASE OF THE LUNGS

Brief Review of the Literature and Report of Two Cases

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BAGASSE disease of the lungs has been known since 1941 when Jamison and Hopkins[3] reported a case from New Orleans presenting with the symptoms of fever, dyspnea, cough productive of clear, white sputum, slight hemoptysis and the roentgen-ray picture of miliary tuberculosis in a man who had worked for four months unloading sugar cane bagasse (the remnant of the cane after extraction of the sugar). Subsequent phenomena of this nature have prompted further correlation of the characteristic pulmonary pattern with inhalation of the dust of the dry sugar cane.

The syndrome is characterized clinically, by malaise, weight loss, fever, extreme dyspnea, substernal pain associated with cough, variable sputum, occasional hemoptysis, and night-sweats. Impaired percussion note, scattered rales, rhonchi, bronchial breath sounds, cyanosis, and clubbing of the fingers are exhibited on physical examination, and elevation of the sedimentation rate, leukocytosis with increase in polymorphonuclear cells, and toxic granulation are found on laboratory study. Polycythemia is sometimes present.[9] The course of the disease may vary from one of gradual clearing upon withdrawal from the polluted atmosphere to residual extensive pulmonary fibrosis or to death,[2, 8] depending on the intensity and duration of the original and subsequent exposures. The only recorded deaths from bagasse disease are reported by Hunter and Perry[2] in England, where the Louisiana bagasse had been shipped for processing prior to use as insulating board, and by Sodeman and Pullen[7, 8] in New Orleans.

Roentgenographically, the primary differential diagnosis rests between miliary tuberculosis, pulmonary carcinomatosis, fungus disease, and pneumoconiosis. Punctate infiltration[5] merges with dense hilar shadows and hilar consolidation of such a nonspecific nature as to preclude a diagnosis by roentgen-ray findings alone without a history of exposure to bagasse dust. Two months after withdrawal of the patient from the hazard, radiographic resolution can be appreciated, and after six months the lung fields of the usual case are normal.

Pathologically, in a fatal case[8] and in one case studied by biopsy by lung puncture,[9] irregular spicules were noted in the interstitial tissues with surrounding fibroblastic reaction. These spicules[7, 8, 9] had the physical property of rotating polarized light as does bagasse. The alveolar cells of a single case were large and had a foamy cytoplasm.[9] Bronchiolitis and bron-

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chiectasis were described in the fatal case of Hunter and Perry together with severe pulmonary and pleural fibrosis, bullous emphysema, anthracosis, and pneumonia. The chronic bronchiolitis and bronchiectasis were thought to be the sequelae of an interstitial pneumonia and acute bronchiolitis postulated earlier in the disease.

CASE REPORTS

The 2 cases which follow occurred in an area where the disease is not prevalent and because of the occupational hazard are thought worthy of a brief report:

CASE 1.—T. T., a 48 year old white, married man, complained of chills, fever, cough, dyspnea, and weight loss of three weeks' acute duration following four months of progressive malaise and fatigability. The past history was not relevant except for a record of malaria in 1947.

In August, 1949, the patient commenced his work as an occasional grinder of sugar cane bagasse. In January, 1951, this became his primary occupation for one month before the progressive symptoms of fatigue, cough, dyspnea, and generalized weakness became prominent. A respiratory wheeze with paroxysmal cough productive of mucopurulent sputum was apparent in March. In May the imposition of a low-grade fever with twice-nightly chills and weight loss of 20 pounds over a five-week period forced him to discontinue his work.

On admission of the patient to the hospital the oral temperature was found to be 100 F. The pulse was 95, the respirations 30, the blood pressure 110/80. The patient weighed 125 pounds. Examination revealed a thin, chronically ill white man whose major positive physical findings, save for injection of the nasopharynx, were confined to the lungs. There were diffuse, coarse rales throughout both lung fields. Although a pleuritic pain was present over the right side of the chest posteriorly, no friction rub was noted. The cardiovascular system was normal. The spleen was readily palpable.

A complete blood count was normal; the sedimentation rate was 49 mm. per hour, corrected; malarial parasites were found in the blood smear; the blood Wassermann reaction was negative; urinalysis was normal. Study of the expectorated sputum as well as that obtained by gastric washing and by bronchoscopy was negative for acid-fast bacilli and for malignant cells. A fungus culture yielded an unidentified budding yeast form but no mycelia. Guinea pig inoculation gave no additional information. Skin tests for blastomycosis, coccidioidomycosis, and histoplasmosis were negative. At bronchoscopy a scanty mucoid secretion of generalized distribution was observed. A chest roentgenogram made June 1, 1951 (fig. 1 left) indicated diffuse infiltration throughout both lung fields. The extreme apices and bases were clear and the process was bilaterally symmetrical. There was thought to be no evidence of cavitation. A chest roentgenogram October 23, 1951 (fig. 1 right) indicated a striking improvement with no discernible abnormality except for increased density of the markings to the right apex.

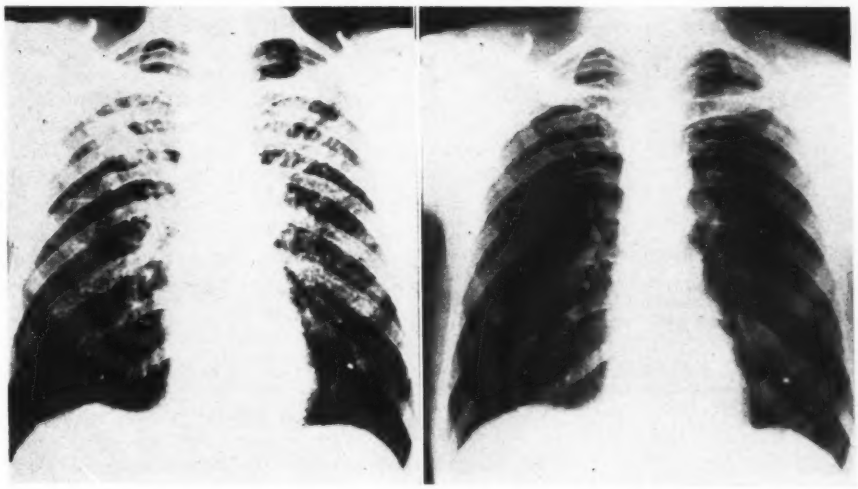

FIG. 1. Left. Chest roentgenogram made June 1, 1951, showing diffuse infiltration throughout both lung fields. The extreme apices and bases are clear. Right. A roentgenogram of the same patient made October 31, 1951, showing noticeable improvement.

Pending the completion of diagnostic studies in June, the patient received aureomycin and streptomycin without dramatic clinical response. Quinine was administered for a period of four days in view of the malarial infestation. The patient was discharged from the hospital on the seventeenth day after an uneventful course. Two weeks later, weight gain and subjective improvement were manifest though a persistent cough productive of culturally benign, mucopurulent sputum remained.

CASE 2.—C. W., a 27 year old Negro man, complained of dyspnea and pain in the anterior portion of the chest of two months' duration. The past history was not pertinent. After eight months of intermittent work which consisted of chopping bagasse bales and feeding the grinding machines, he observed progressive dyspnea, pain in the anterior part of the chest, a morning cough which was productive of whitish sputum, fever of unrecorded proportions, and weight loss of 15 pounds. On admission to the hospital in August, 1951, he was found to have a temperature of 99 F., a pulse of 80 and respirations of 30. The blood pressure was 110/70.

He was a well developed and well nourished Negro man in no immediate distress. Dullness was present at both apices and generalized fine and coarse rales were noted throughout both lung fields. No murmurs were apparent over the precordium. The abdominal organs were not enlarged.

Results of a complete blood count follow: red blood cells 5.1 million, hemoglobin 13.5 Gm.; white blood cells 10,600; polymorphonuclears 82 per cent; lymphocytes 13 per cent; monocytes 5 per cent; eosinophils none. The sedimentation rate was 42 mm. per hour, corrected; the blood Wassermann reaction was negative. Cultures of the sputum were negative for tubercle bacilli on three separate occasions; routine throat culture yielded only the usual organisms; fungus cultures grew Aspergillus. Tuberculin and coccidioidin skin tests were negative at forty-eight hours. A histoplasmin skin test, using 0.1 cc. of histoplasmin 1:100, was 2 plus at forty-eight hours. Roentgenogram of the chest on June 23, 1951 (fig. 2 left) showed widespread, soft infiltrations scattered throughout both lung fields. There was no evidence of pulmonary cavitation. The apices and bases were clear, bilaterally. Striking resolution of the pulmonary lesions was noted on a film made September 18, 1951 (fig. 2 right).

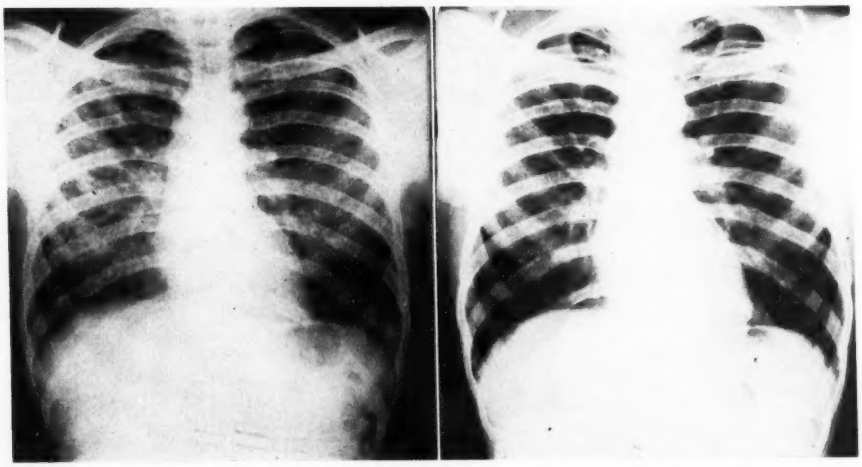

FIG. 2. Left. Chest roentgenogram made June 23, 1951, showing widespread, soft infiltration scattered throughout both lung fields. Right. A roentgenogram of the same patient made September 18, 1951, indicating marked resolution of the pulmonary lesions.

Prior to admission to the hospital in August, the patient received penicillin by inhalation, streptomycin, and chloramphenicol. No specific therapy was administered during hospitalization. During his fourteen day hospital stay, the patient's temperature varied between 98 and 99.2 F. In the three months after discharge from the hospital there was a weight gain of 8 pounds.

DISCUSSION

The specific etiology of bagasse disease is not known, though the correlation with exposure to the dust of the dry sugar cane is consistent. The disease has its highest incidence in those who work most intimately with the dry dust, namely, the packers and the grinders. In reporting a series of 10 cases, Hunter and Perry[2] stated that almost half of the men working on a dry shredder developed this acute respiratory illness after approximately eight weeks. In an effort to establish the possible role of silica, Nagelschmidt[6] found that bagasse consists of 3 per cent ash. Of the ash 50 per cent is amorphous silica and 5 per cent is quartz. Hunter and Perry reasoned that this minute amount of silica is not sufficient to produce a pneumoconiosis. Sodeman and associates,[10] injecting the silicon fraction into guinea pig peritoneum, noted but little reaction. Furthermore, the usual course of uncomplicated bagasse disease is one of gradual improvement and complete resolution of the lesions evident with roentgen-ray from three to six months after cessation of exposure, a reversibility which is not seen with silicosis.[7]

The role of fungus infection in bagasse disease has not been fully evaluated other than to note the presence of such varied molds[2] as Aspergillus, Candida, Paleomyces, Mucor, and Rhizopus. It has been suggested that these positive cultures may result merely from the recent inhalation of the fungus, rather than from a bona fide mycotic infection of the lung.[2] Sodeman[7] and LeMone[5] have expressed the opinion, on the other hand, that there is more than a foreign body reaction since heat-processing of the bagasse seems to vitiate the hazard of pneumonitis by destroying postulated pathogenic fungi as well as bacteria and potentially allergenic factors. Exposure to dust after heat-processing has not yet been shown to produce the syndrome,[7] nor has experimental production of the disease been accomplished.

Numerous bacteria have been cultured from the sputum, Streptococcus viridans, Pneumococci, Neisseria catarrhalis, fusiform bacilli, and so forth. There

is no evidence, however, that any is pathologically reprehensible. Multiple efforts have been made, of course, to incriminate the tubercle bacillus, but the search has been fruitless and the incidence of positive tuberculin reactions appears to be no greater in those afflicted with bagasse disease than in a random group.

Castleden and Hamilton-Paterson[1] have studied the allergic possibilities of bagasse and have found that 3 patients reacted with positive skin tests to saline extract of bagasse. They suggested that the initial portion of the illness may be due to an allergic response to crystallin cellulose with or without the mycotic or bacterial contaminants. Sodeman and Pullen,[9] in an effort to confirm this work, observed that controls with no history of exposure to bagasse also reacted to saline extracts. The reported skin reaction thus suggests a local "irritation phenomenon" of questionable significance. The eosinophilia has ranged from 0 to 8 per cent.[5, 9] No parallel can be drawn between the pulmonary infiltration with circulating eosinophilia described by Loeffler and the syndrome under scrutiny. The diseases are dissimilar clinically, radiographically, and pathologically.

Bagasse disease is thus a grave industrial hazard with a mortality of 4 persons in about 40 recognized cases. It is probable, however, that many cases have occurred and the patients recovered without diagnosis.

The practical considerations dictate that specific measures for protection from the dust are necessary. Wetting of the bale before shredding, routine use of filters, and adequate ventilation have been effective. It is not thought that antibiotic therapy contributed to the favorable outcome in the 2 cases here presented. After removal from the contaminated atmosphere, the severely ill patient may profit from oxygen and other supportive and palliative measures. The appearance of the syndrome as described should lead to prompt withdrawal of the patient from the bagasse before irreversible damage occurs.

SUMMARY

Bagasse disease of the lungs is a serious industrial hazard in areas where sugar cane bagasse is processed. Two cases occurring in Texas are reported with a brief review of the literature and discussion of the possible role of silica, fungus and bacterial infection, and hypersensitivity. Radiographic differentiation from miliary tuberculosis, pulmonary carcinomatosis, mycosis, and pneumoconiosis is difficult. Early recognition of the syndrome and withdrawal of the patient from the hazard are essential to his welfare.

The authors acknowledge with thanks the permission of Dr. Elliot S. Phillips to report these cases.

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Plastic Surgical Dressing for Wounds

An experimental "spray on" plastic surgical dressing developed by the United States Air Force for possible emergency use in case of atomic attack or other large scale disasters may prove effective for general use in treatment of many types of surgical wounds.

"Aeroplast," the name given the transparent plastic dressing, is applied directly to burned or injured areas from an aerosol type pressurized container and provides instant protection. In tests conducted so far gauze bandage dressings were unnecessary when this plastic was used.

As a result of many tests, the plastic dressing is believed to be effective clinically as a general surgical dressing. Advantages of its use include timesaving application, transparency to permit easy inspection of the wound, and ease in removing or changing dressing as well as usefulness in application to parts of the body poorly adapted to gauze dressings.

Additional advantages recognized in the event of large scale disasters include the quick application by an untrained person and its inexpensiveness in comparison with gauze. The plastic dressing is portable and great quantities can be stored indefinitely in a minimum of space. The dressing will not halt an infection already present, reports the Air Force's Research and Development Command, but will prevent infection of a wound that is cleansed before its application.

TEXAS DOCTOR WRITES ON CANCER

Dr. James W. Hendrick, San Antonio, and Dr. Grant E. Ward, Baltimore, writing in the November 15 issue of *The Journal of the American Medical Association*, have stated that cancer within the mouth accounts for approximately 8 per cent of all human malignant diseases. The doctors state that the greatest incidence of such cancers is between the age of 50 and 60 years, with men being affected five times as often as women. Because cancers within the mouth frequently spread to other parts of the body, it is essential not only to eradicate the primary lesion, but also the involved lymph nodes, which transmit the cancer to other parts of the body. These cancers may be treated with irradiation, electrosurgery, surgery, or a combination of these methods, according to the two physicians.

MASSIVE RUPTURE OF THE LIVER

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MASSIVE rupture of the liver is, fortunately, a relatively rare clinical entity, but it poses a situation fraught with the most dire and urgent potentialities into which any doctor subject to emergency call may be catapulted on a moment's notice. Because of this—because any physician may encounter it today—this case seems worth presenting in the attempt to show how rupture of the liver is such a fatal thing as to demand an all-out effort and how such an all-out effort may be successful in saving the patient.

CASE REPORT

I was called one bright May morning to see Mrs. E. S., aged 44, who had been thrown from a horse some 5 miles from town. She lay where she had fallen, pale and sweaty, obviously in great pain and in extreme shock. Her radial pulse was barely perceptible; I thought she might die in a few minutes. She was given morphine and Dilaudid and by the time she reached the hospital was a little better.

Examination at the hospital showed the patient conscious, lying quite still, with moist, clammy skin, blood pressure less than 50 mm. of mercury systolic, and all the signs of extreme circulatory collapse. There was marked tenderness in the right axilla. The abdomen was soft and not distended. No spinal tenderness was noted. Roentgenograms of the chest revealed fractures of the seventh, eighth, ninth, and tenth ribs in the right axilla with varying degrees of displacement. The chest was otherwise clear. Administration of plasma and intravenous fluids was begun at once followed by transfusion at the earliest possible moment.

It became apparent during the afternoon as all efforts to stabilize the patient's flagging blood pressure continued to be futile that she presented the picture of severe and unchecked hemorrhage which was not in the chest. Toward evening the abdomen, which had been soft and normal, became distended and showed evidence of intra-abdominal fluid. The diagnosis of intraperitoneal hemorrhage from massive rupture of the liver was inescapable, as was also the decision to operate as the only possible course compatible with survival. The patient was in no shape for surgery, nor had she been at any time since injury, but there was no alternative. Massive rupture of the liver is not amenable to conservative nonoperative treatment.

At 9 p. m. the operation was begun. Through a right subcostal incision the abdomen was opened—with a great gush of blood. As this was cleared away, a large rent in the right side of the liver was noted, extending up over its dome. Much of the right lobe was torn loose except for a small connecting pedicle. Blood welled in a steady stream from the dismal depths of the wound. Time was short. Through-and-through sutures were placed in a hurried effort to close the rent in the liver, the upper part of which was then packed with Oxycel gauze. The use of two gauze packs to discourage the bleeding further was a measure of desperation and not of choice. One pack was placed over the dome of the liver in the gaping rent still visible and inaccessible to suture, and the other between the liver and ribs laterally to compress the right lobe against the liver proper. The incision was rapidly closed. Blood pressure and pulse were imperceptible, but the patient breathed.

During the afternoon prior to operation 1,800 cc. of plasma, 1,000 cc. of Ringer's solution, and 1,000 cc. of blood were given. While the operation was in progress, the patient was kept alive by transfusion of 2,000 cc. of blood. Following operation transfusion of 3,500 cc. of blood was continued until 6 a. m., when the patient's pressure was stabilized at 110/80. During these eighteen hours she received a total of 9,300 cc. of blood, plasma, and Ringer's solution. Her urinary output for this period was 240 cc. At 1 p. m. on the second day she was taking fluids by mouth; she was no longer in shock and had a pulse rate of 106 and blood pressure of 104/76. The first round was over and the patient settled down to the long business of getting well, fortified by morphine and antibiotics with the oxygen tent and the Levin tube as constant companions.

A peculiar cyanosis noted in the first few days became a definite jaundice by the end of the week. At that time there was evidence of fluid in the chest, fluid in the abdomen, and jaundice of the hemolytic type. By the end of the third week the patient's condition was considered good enough to attempt removal of the gauze packs. Under Pentothal anesthesia these packs were pulled out as carefully as possible but not without considerable effort. The anticipated bleeding did not occur at this time and there was no shock. Urinary output continued adequate.

In the next three days the patient's condition deteriorated steadily in spite of transfusions (2,000 cc. of blood). On the third day there was a sudden gush of blood from the wound. On the fourth day there was much pain in the back and right shoulder followed by a furious arterial hemorrhage and shock. When it seemed that everything was lost and that the patient and doctors were through, the bleeding miraculously stopped. It recurred slightly on the fifth day but not thereafter. The second round was over and things began to be better.

Subsequent complications were fluid in the right side of the chest, removed by aspiration; a collection of 2,000 cc. of sero-sanguino-purulent fluid in the lesser peritoneal cavity, evacuated by aspiration through the overhanging edge of the liver above the stomach; and a large collection of sero-purulent fluid drained by a muscle-splitting incision in the right lower quadrant.

Improvement was gradual but steady, and the patient was able to leave the hospital three months after injury. At the end of seven months, she had regained most of her normal weight and was practically well.

COMMENT

Subcutaneous rupture of the liver usually is a fatal injury. It is rare in civilian practice but common on the autopsy tables that receive the pitiable wreckage of fatal airplane and automobile accidents. Hospital incidence is low because most of these patients die immediately or so soon after injury that there is not time to get them to the hospital for treatment. In a series of 21 cases reported by Vance,[6] 33.3 per cent of patients died at the site of injury, 38.1 per cent died in the first six hours after injury, and 28.1 per cent lived long enough for adequate study.

Read before the Texas Surgical Society, Houston, April 7, 1952.

Wright[8] reported 32 cases of rupture of the liver without penetrating wounds from the traumatic service of the Harlem Hospital (27 in 34,000 admissions) from 1935 to 1946, but only 1 in the three years of gas rationing.

Mikal and Papen[3] gave a thorough analysis of 45 such cases treated at the Boston City Hospital from 1945 to 1950.

The outstanding symptom of massive rupture of the liver is shock—immediate, profound, and persistent. Symptoms of intra-abdominal injury—pain, rigidity, distention, and fluid dullness—may not develop for six hours or more. Prompt diagnosis thus may be difficult, but the picture of extreme hemorrhagic shock in a patient with multiple rib fractures (37.5 per cent) should engender a strong suspicion of the true state of affairs. Peritoneal aspiration is a worth-while diagnostic procedure.[8]

The treatment of massive rupture of the liver resolves itself into replacement of blood loss—prompt and continuous—and operation to stop the bleeding as soon as the diagnosis is made or strongly suspected, regardless of the condition of the patient. Suture of the lacerated liver is rarely effective. The hemorrhage is best controlled by packing the rent with gauze, preferably absorbable gauze. The routine advised by Mikal and Papen[3] and used at the Boston City Hospital is (1) administering whole blood for shock; (2) performing early operation; (3) packing the liver laceration with absorbable hemostatic sponges; and (4) closing the abdomen without drainage. To this Wright[8] would add close personal observation. And before, during, and following operation should be added supportive treatment with every means available for sustaining life.

Pathologic studies made at operation or autopsy indicated that the right lobe is lacerated six times more often than the left. The dome of the liver was involved in 43.7 per cent of Wright's cases. In immediately fatal cases diffuse laceration of the liver was the rule. In 1 patient reported by Localio and Salz[2] who survived for seventy days before coming to autopsy, there was no regeneration of the injured right lobe but a marked compensatory hypertrophy of the left lobe.

In Wright's series of 32 cases death occurred in 25 cases. Of 17 patients not treated surgically, all died. Nine of 15 patients treated surgically died. Of these 6 who lived after surgery, all were packed with gauze at operation. Deaths in the series of 40 cases reported by Mikal and Papen totalled 25; 18 of the 22 nonoperative patients died. Seven deaths occurred among the 18 operated upon. When surgery was performed within three hours after injury, approximately one-third of the patients died; when surgery occurred after three hours, about two-thirds died; and after twelve hours, none of the patients died. The low mortality after twelve hours was due to less urgent and less massive injuries. In Mikal's last 4 cases, treated by the routine outlined previously, there have been no deaths. These results indicate that nonoperative treatment has no place in rupture of the liver.

Most noteworthy feature of the case here reported is the fact that the woman survived the first few hours and got well. Some credit for this must be given to those who had the good sense to let her lie where she fell until she could be properly moved.

Another striking feature was the immediate onset of profound shock long before any other evidence of abdominal hemorrhage was apparent. This is typical of massive rupture of the liver. There was not at any time a favorable opportunity for surgical intervention, and when the diagnosis was made, the decision to operate was a measure of desperation without which there was no hope.

The case illustrates the use of plasma, fluids, and blood in quantities sufficient to combat shock and replace blood loss. My associate in this case, Dr. James W. Short, had had considerable experience in the treatment of severely wounded and shocked Marines in the ordeals of Saipan, Iwo Jima, and Okinawa, and had learned that such cases can be saved if enough blood—plenty of it—is available and is used. The faithful and persistent application of that principle in the long hours between midnight and dawn contributed much to the subsequent successful outcome of this case. It was this patient's good fortune to have been hurt in a locality where enough blood could be had immediately—from the bank at the Harris Hospital—and when that supply was exhausted, from the bank at St. Joseph's Hospital—and finally from friends and from the Naval Base at Grand Prairie. She received in the first eighteen hours 6,500 cc. of citrated blood, 1,800 cc. of plasma, and 1,000 cc. of Ringer's solution—a total of 9,300 cc. Any less would not have turned the tide.

Oxycel was used to staunch the bleeding in that part of the wound of the liver which could not be reached for suture. All the hospital had was used; we needed more. The use of Oxycel in surgery is always a measure of desperation; surgeons resort to it when they cannot stop hemorrhage by tie or suture. There is a "retained Oxycel sponge syndrome."[7] The serosanguinous abscess of the lesser peritoneal cavity subsequently complicating our case was probably part of this syndrome.

Large gauze packs often have been used in liver wounds. We used them because we thought that they might help control the bleeding from the dome of the liver. Their removal became, as it always is, a major problem, and we deferred it as long as we dared. It is significant that the severe hemorrhage which followed

their removal was not immediate but came four days later. Their use is to be condemned if it can be avoided. In this instance, however, one may well find himself in sympathy with Babcock[1] when he said, "In many cases the patient is in such bad condition or the liver so friable that firm packing with a continuous strip of folded gauze is the only permissible treatment." Also one is impressed by the fact that of Wright's 6 patients who survived, all were packed with gauze.

Jaundice was a complication of this patient's convalescence. It appeared on the sixth day and was marked on the ninth day following injury. It was not associated with clay colored stools or bile drainage; it persisted for about two weeks and gradually cleared.

Other surgical complications have been mentioned: collections of fluid in the lesser peritoneal sac and in the right lower quadrant, abdominal distention, and a high degree of protein starvation with extreme muscular wasting and occasional edema of the feet and ankles, which was always helped by more blood.

Amenorrhea persisted for six months, during which time the patient developed a marked growth of hair on her face and other hairy surfaces. It is possible that this was the result of the use of large quantities of masculine blood with suppression for a time of ovarian activity. After menstruation was resumed, the hirsute tendencies gradually disappeared.

Examination at the end of a year showed this patient at about her normal weight, resuming her normal activities—all except horseback riding. She has little to show for her illness except a few scars and an increasing hernia at the site of the gauze packs.

SUMMARY

A case of massive rupture of the liver is reported, complicated by extreme hemorrhagic shock, and necessitating an all-out effort with all the methods at hand for treating such an emergency situation. It is reported here as a surgical experience that may be of value to anyone who may encounter such a case.

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DOUBLE CONTRAST MANIFESTATIONS OF NONPOLYPOID COLON DISEASES

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THE double contrast examination of the colon is the method of choice for determining the presence or absence of small polypoid lesions of the colon. It is generally accepted that the clinical indications for this examination are (1) polyps visualized by proctoscopic examination, (2) any amount of rectal bleeding (bright red or dark), (3) history of polyps previously found, and (4) history of previous colon resection for carcinoma.

The double contrast examination consists of the introduction of barium and air into the colon. To obtain satisfactory roentgenograms, a fairly rigid technique must be followed. This procedure is given in detail in a recent article.[1]

Over a period of years we have found the double contrast examination to be of definite aid in the diagnosis of other than polypoid lesions. The advantages of this procedure are the ability to "see through" from one loop of colon to the other and the ability to determine whether deformity of the bowel wall is due to extrinsic pressure, disease of the wall itself, or intraluminal extension of a neoplasm.

Read before the Section on Radiology, Texas Medical Association, Annual Session, Dallas, May 6, 1952.

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CASE REPORTS

The following case reports illustrate a variety of conditions in which the double contrast examination was helpful in arriving at a correct diagnosis.

CASE 1.—The patient was a 43 year old white woman with a chief complaint of pain in the upper part of the ab-

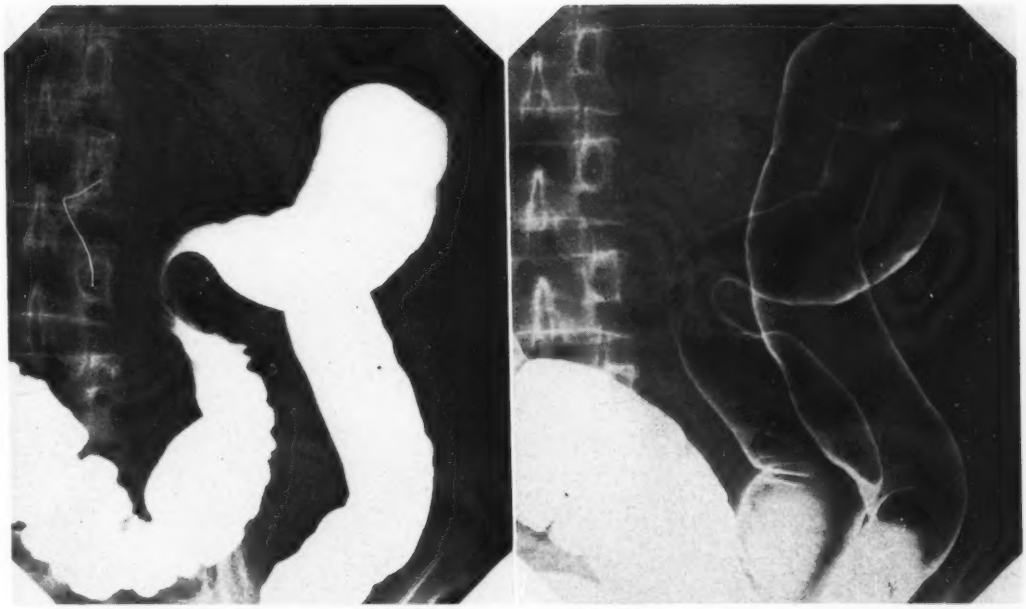

FIG. 1. Left. Case 1. Constricting lesion shown by single contrast. Right. Double contrast of the same area as at left.

domen. Gallbladder surgery had been performed on her one year previously at which time a choledochojejunostomy was done. After this operation, she developed symptoms of mild intermittent partial intestinal obstruction. Roentgenologic examination of the colon showed a narrowing in the distal portion of the transverse colon (fig. 1 left). During fluoroscopy this area could not be distended and the question arose as to whether or not this was an intrinsic lesion such as a stricture or benign tumor. In an effort to obtain more information about the area, the double contrast examination was done. These roentgenograms clearly showed a normal lumen and bowel wall with the deformity being due to extrinsic pressure (fig. 1 right). A large band of adhesions from the previous surgery was found to be the cause of this defect.

CASE 2.—The patient was an 81 year old man who complained of abdominal pain and distention, considerable weight loss, no appetite, and recent black stools. On examination, there was a large fixed mass lying deep in the pelvis and left lower quadrant.

Roentgenologic examination of the stomach revealed it to be markedly dilated, filled with secretion, and obstructed at the outlet.

Fluoroscopy of the colon showed a marked narrowing in the rectosigmoid region, but because of multiple angulations and redundancy of the sigmoid, this area was obscured by barium in these loops. The double contrast examination enabled us to "see through" the multiple loops and prove that the wall was intact and that there was no intraluminal lesion (fig. 2). None of the signs of primary carcinoma were present and we concluded that this was an extrinsic pressure defect. On surgical exploration this extrinsic deformity was found to be due to a large mesenteric mass of carcinomatous tissue which had metastasized from a carcinoma of the stomach.

CASE 3.—A 41 year old man entered the clinic complaining of episodes of severe diarrhea, bloody stools, abdominal pain, and tenderness during the past three years. Endamoeba histolytica had previously been recovered from his stools and various antiamebic measures had been instituted without improvement.

The patient was studied by proctoscopy and a type of chronic ulcerative colitis was found to involve the rectum and rectosigmoid.

During fluoroscopic examination of the colon two relatively short lesions were discovered, one in the proximal sigmoid and the other in the transverse colon near the splenic flexure. The short length of the lesions was the only sign favorable to a diagnosis of carcinoma. There was no attempt at proximal or distal intussusception and the change from normal bowel wall to abnormal was not sudden.

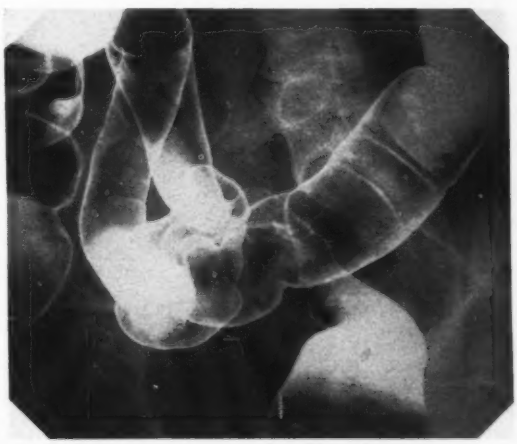

FIG. 2. Case 2. Double contrast of a sigmoidal defect due to extrinsic pressure.

FIG. 3. Left. Case 3. Double contrast of amebic granuloma in the sigmoid colon.

Right. Double contrast of amebic granuloma in the transverse colon in the same patient.

FIG. 4. Left. Case 4. Polypoid defect in the tip of the cecum.

Right. The same defect shown to be due to a deformed wall from inversion of the appendiceal stump.

Double contrast roentgenograms showed no evidence of polypoid growth but did show multiple small tracts of ulceration extending out from the bowel wall (fig. 3). This enabled us to make a diagnosis of constricting segmental ulcerative colitis probably amebic in origin.

CASE 4.—This 47 year old man entered the hospital with a history of intermittent diarrhea and constipation for a period of three months. This had been accompanied by lower abdominal pain and a 20 pound weight loss.

At proctoscopic examination an adenocarcinoma was found at 15 cm. The colon examination showed this lesion plus a 7 mm. polyp in the upper descending colon. The presence of a third polyp in the hepatic flexure was suggested.

Surgery was done and the rectosigmoid resected. The polyp in the descending colon was also removed. Both lesions were reported as grade 1 adenocarcinomas. An appendectomy was done.

Reexamination of the colon by the double contrast method four months later showed the small 3 by 4 mm. polyp still present in the hepatic flexure, but there now was a polyp-like area 2 cm. in diameter in the tip of the cecum which was not present before (fig. 4). Because the double contrast roentgenograms are made in stereo-pairs, one of the films showed that this polyp-like area was actually an invaginating defect of the cecal wall due to surgical inversion of the appendiceal stump.

CASE 5.—This patient was a 39 year old white woman. She gave a history of cramping pain in the lower part of the abdomen occurring just before and during her menstrual periods. This pain was associated with tenessmus and a mucosanguinous rectal discharge.

During fluoroscopic examination of the colon a very short defect was noted on one wall of the rectosigmoid area of the colon. To rule out a large polyp attached to the bowel at this site the double contrast examination was resorted to (fig. 5). An intraluminal lesion could definitely be ruled out and extrinsic pressure was indicated. Surgical exploration confirmed this diagnosis and proved the extrinsic mass to be an endometrioma.

CASE 6.—This 23 year old woman complained that for two years she had been constantly vomiting food three to four hours after eating. This vomiting was accompanied by nausea but no pain. She had also noted diarrhea for the past two or three months.

Because of the history of diarrhea, we did not start the colon examination with the idea of doing the double contrast procedure. Fluoroscopy of the colon showed no abnormality, but as the terminal ileum was filled a long narrow constricting lesion was noted (fig. 6 left). The patient was instructed to evacuate the barium and then we introduced air and easily obtained double contrast visualization of the terminal ileum. The diagnosis of regional enteritis involving the terminal ileum was easily made during fluoro-

FIG. 5. Case 5. Double contrast of a region in the sigmoid involved by endometriosis.

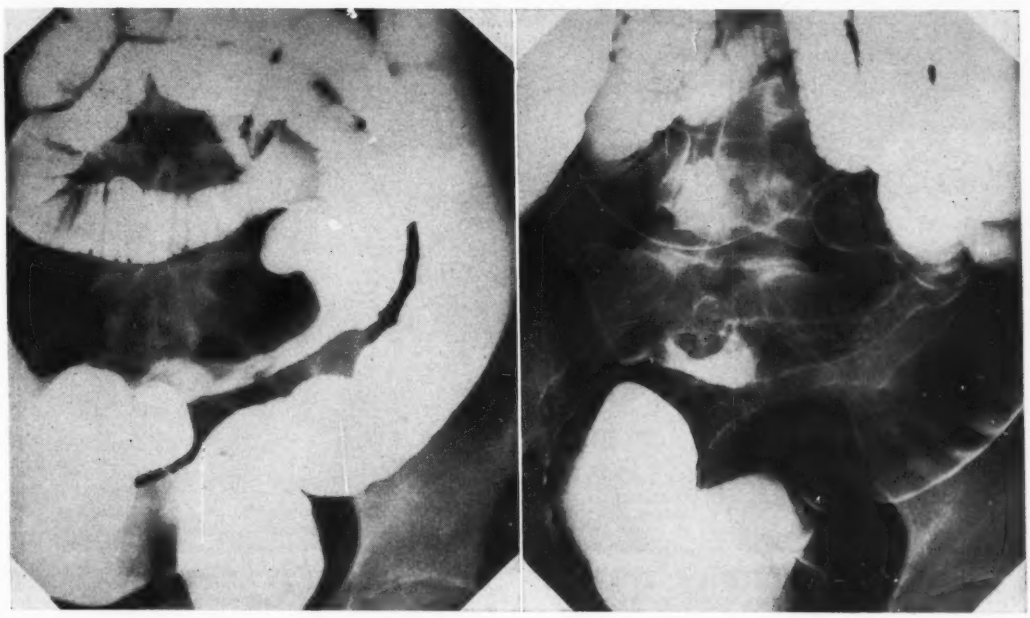

FIG. 6. Left, Case 6. Terminal ileitis shown by single contrast. Right. Double contrast of the same area.

FIG. 7. Left. Case 7. Meckel's diverticulum demonstrated by double contrast.

Right. Case 8. Extensive idiopathic chronic ulcerative colitis. Note the granular mucosa.

FIG. 8. Left. Case 9. Segmental ulcerative colitis shown by single contrast.

Right. Double contrast of the same area. Note the pseudopolypoid hyperplasia of mucosal islands.

scopy, but the double contrast enabled us to "see inside" the ileum and note the sudden termination of the ileitis about 11 cm. from the ileocecal valve (fig. 6 right). This case illustrates the fact that it is possible to examine the terminal ileum by the double contrast procedure and that information not otherwise possible may be obtained.

CASE 7.—This 69 year old woman gave no complaints referable to the gastrointestinal tract, but a single small polyp was discovered on routine proctoscopic examination. Double contrast examination of the colon showed no evidence of polyps or other disease, but a Meckel's diverticulum was noted in the ileum (fig. 7 left). This case again demonstrates the feasibility of examining the terminal ileum by the double contrast method.

CASE 8.—A 65 year old woman came to the clinic complaining of diarrhea of twenty years' duration. This was characterized by exacerbations and remissions. Occasionally she passed bright red blood in stools and had abdominal cramping.

Proctoscopic examination showed the typical appearance of idiopathic chronic ulcerative colitis. Because of typical proctoscopic findings, we decided against the double contrast examination as a primary procedure and did complete fluoroscopy to determine the extent of the disease. After we determined that the entire colon was involved the double contrast examination was done and showed the markedly granular mucosa (fig. 7 right). These roentgenograms will serve as comparison for future examinations, for approximately 5 per cent of these patients will develop a carcinoma of the colon.

CASE 9.—This 32 year old man entered the hospital complaining of rectal fistulas for five years. Physical examination showed two fistulous tracts opening around the anus.

Again in this instance the single contrast examination was done to determine the extent of the disease and make possible the diagnosis of segmental chronic ulcerative colitis (fig. 8 left). The double contrast examination then gave added information in regard to the mucosa and showed a typical area of pseudopolypoid hyperplasia due to islands of regenerating epithelium (fig. 8 right).

CONCLUSIONS

By means of the cases presented here, we have endeavored to show that, in addition to its use in the demonstration of polyps, the double contrast colon examination may be used to furnish additional information about lesions of a nonpolypoid nature. At times, this procedure affords considerable aid in differential diagnosis.

Therefore, we may conclude that a fifth indication for the double contrast procedure may be added to the previously mentioned list of four, namely, (5) to obtain additional information regarding a lesion discovered by the single contrast method, and as an aid in the diagnosis of lesions of the terminal ileum.

REFERENCES

1. Stevenson, C. A.: Technic of Double Contrast Examination of Colon, Surg. Clin. N. America, Oct., 1952, pp. 1531-1537.

ABSTRACT OF DISCUSSION

DR. R. N. SMITH, Harlingen: Dr. Hartman and I have been doing double contrast studies routinely and have found a few very small polyps which could not have been found using a plain barium enema. Incidentally, these small polyps had not caused bleeding.

For patients with symptoms referable to the right lower quadrant of the abdomen, most radiologists prefer to use the plain barium enema in order to obtain more complete filling of the cecum and terminal ileum; but here too, as the essayists pointed out, the double contrast study is useful.

With recent improvements in technique especially the use of the Moreton Y-tube, the time required for the examination has been reduced by one-half, and it is possible that in the future the double contrast study of the colon will be a routine procedure.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Houston, April 28-29, 1953. Dr. T. C. Terrell, Fort Worth, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, Denver, Dec. 2-5, 1952. Dr. Louis H. Bauer, Hempstead, N. Y., Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy. Dr. Walter S. Burrage, Milwaukee, Pres.; Mr. James O. Kelley, 208 E. Wisconsin Ave., Milwaukee 2, Executive Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 6-11, 1952. Dr. C. Guy Lane, Boston, Pres.; Dr. John E. Rauschkolb, 25 Prospect Ave., N. W., Cleveland 15, Secy.

American Academy of General Practice, St. Louis, March 23-26, 1953. Dr. R. B. Robins, Camden, Ark., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 15-17, 1952. Dr. Carl P. Huber, Indianapolis, Pres.; Dr. Ralph A. Reis, 116 S. Michigan Ave., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Frederick C. Cordes, San Francisco, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics. Dr. Phillip Barba, Philadelphia, Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, San Francisco, March 27-30, 1953. Dr. Robert M. Janes, Toronto, Canada, Pres.; Dr. Paul C. Samson, 2938 McClure St., Oakland 9, Calif., Secy.

American Association of Genito-Urinary Surgeons, Hot Springs, Va., May 6-8, 1953. Dr. A. J. Scholl, Los Angeles, Pres.; Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 10-12, 1953. Dr. Nicholson J. Eastman, Baltimore, Pres.; Dr. William F. Mengert, 2211 Oak Lawn Ave., Dallas, Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Exec. Vice-Pres.

American College of Allergists, Dr. J. Warrick Thomas, Richmond, Va., Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, New York, May 28-31, 1953. Dr. Andrew L. Banyai, Milwaukee, Pres.; Mr. Murray Kornfield, 112 E. Chestnut St., Chicago 11, Exec. Secy.

American College of Physicians, Atlantic City, April 13-17, 1953. Dr. T. Grier Miller, Philadelphia, Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb., 1953. Dr. John S. Bouslog, Denver, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Chicago, Oct. 5-9, 1953. Dr. Harold L. Foss, Danville, Pa., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress of Physical Medicine, Chicago, August, 1953. Dr. Walter M. Solomon, Cleveland, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Lake Placid, N. Y., June 9-13, 1953. Dr. Earl D. Osborne, Buffalo, Pres.; Dr. L. A. Brunsting, 102 2nd Ave., S. W., Rochester, Minn., Secy.

American Gastro-Enterological Association, Atlantic City, May 1-2, 1953. Dr. Albert M. Snell, Palo Alto, Calif., Pres.; Dr. H. Marvin Pollard, 1313 E. Ann St., Ann Arbor, Mich., Secy.

American Gynecological Society. Dr. William P. Healy, New York, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Hospital Association. Dr. Anthony J. J. Rourke, San Francisco, Pres.; Mr. George P. Bugbee, 18 E. Division St., Chicago, Executive Secy.

American Laryngological, Rhinological, and Otological Society, New Orleans, April 28-30, 1953. Dr. Francis E. Le Jeune, New Orleans, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Atlantic City, June 15-17, 1953. Dr. Hans H. Reese, Madison, Wis., Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, Hot Springs, Va., May 28-30, 1953. Dr. Conrad Berens, New York, Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association. Dr. James Dickson, Cleveland, Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Atlantic City, May 6-8, 1953. Dr. Irvine McQuarrie, Minneapolis, Pres.; Dr. Aims McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, Boston, June 10-13, 1953. Dr. Newton D. Smith, Rochester, Minn., Pres.; Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, N. Y., Secy.

American Psychiatric Association, Los Angeles, May 4-9, 1953. Dr. D. Ewen Cameron, Montreal, Canada, Pres.; Dr. R. Finley Gayle, 6300 Three Chopt Rd., Richmond 21, Va., Secy.

American Public Health Association. Dr. Gaylord W. Anderson, Minneapolis, Pres.; Dr. R. W. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists. Dr. C. Walter Metz, Denver, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists. Dr. Israel Davidsohn, Chicago, Pres.; Dr. Clyde G. Culbertson, Indiana University School of Medicine, Indianapolis, Secy.

American Surgical Association, Los Angeles, April 1-3, 1953. Dr. Robert S. Dinsmore, Cleveland, Pres.; Dr. Nathan Womack, Chapel Hill, N. C., Secy.

American Urological Association, St. Louis, May 11-14, 1953. Dr. George F. Cahill, New York, Pres.; Dr. C. H. DeT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons. Dr. Charles L. Farrell, Pawtucket, R. I., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter. Tri-State Assembly, Dallas, Feb. 5-7, 1953. Dr. H. W. Meyerding, Rochester, Minn., Pres.; Dr. Arnold S. Jackson, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Los Angeles, May 18-22, 1953. Dr. Sidney J. Shipman, San Francisco, Pres.; Mr. Kemp D. Battle, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Cincinnati, Dec. 7-12, 1952. Dr. Joseph C. Bell, Louisville, Ky., Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association. Dr. R. J. Wilkinson, Huntington, W. Va., Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association. Dr. R. Burke Suitt, Durham, N. C., Pres.; Dr. Newdigate M. Owensby, Medical Arts Bldg., Atlanta, Ga., Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 9-11, 1952. Dr. I. Mims Gage, New Orleans, Pres.; Dr. John C. Burch, 2112 West End Ave., Nashville 5, Tenn., Secy.

Southwest Allergy Forum, Kansas City, Mo., 1953. Dr. Orval R. Withers, Kansas City, Mo., Pres.; Dr. James Holman, Medical Arts Bldg., Dallas, Secy.

Southwest Regional Cancer Conference. Secy., 209 Medical Arts Bldg., Fort Worth.

Southwestern Medical Association. Dr. James Walsh, Douglas, Ariz., Pres.; Dr. W. W. Schuessler, 1415 First National Bank Bldg., El Paso, Secy.

Southwestern Surgical Congress. Dr. Michael E. DeBakey, Houston, Pres.; Dr. C. R. Rountree, 1227 Classen, Oklahoma City 3, Secy.

Tri-State Medical Assembly. Dr. Frank G. Thibault, El Dorado, Ark., Pres.; Dr. Albert M. Hand, Le Bonheur Children's Hospital, Memphis 3, Tenn., Secy.

United States-Mexico Border Public Health Association, Ciudad Juarez, Chihuahua, Mexico, 1953. Dr. Salvador Molina Velez, Nuevo Leon, Mexico, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. S. D. Coleman, Navasota, Pres.; Dr. Neil D. Buie, Marlin, Secy.

State Tumor Clinic, Wichita Falls, April 1, 1953. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

Texas Academy of General Practice, Dallas, Sept. 21-23, 1953. Dr. C. U. Callan, Rotan, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine, Dallas, Dec. 6-7, 1952. Dr. W. C. Dine, Amarillo, Pres.; Dr. John S. Chapman, 3810 Swiss Ave., Dallas. Secy. Meetings restricted to members.

Texas Air-Medics Association, Houston, April 27, 1953. Dr. Claire F. Miller, Waco, Pres.; Dr. J. S. Minnett, 2512 Welborn, Dallas, Secy.

Texas Association of Blood Banks, Galveston, Dec. 5-6, 1952. Dr. E. E. Muirhead, Dallas, Pres.; Miss Marjorie Saunders, 3500 Gaston Avenue, Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Fort Worth, Feb. 13-14, 1953. Dr. George Adam, Houston, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, Houston, April 27, 1953. Dr. Robert B. Morrison, Austin, Pres.; Dr. Samuel Topperman, East Texas State Sanatorium, Tyler, Secy.

Texas Club of Internists. Dr. Herbert Hill, San Antonio, Pres.; Dr. Hatch W. Cummings, Jr., 203 Hermann Professional Bldg., Houston, Secy.

Texas Dermatological Society, Houston, April 26-27, 1953. Dr. C. H. McCuistion, Austin, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Houston, April 26, 1953. Dr. E. K. Doak, Houston, Pres.; Dr. Ivan Mayfield, 1318 Main, Lubbock, Secy.

Texas Division, American Cancer Society, Austin, Jan. 16-17, 1953. Mr. Frank C. Smith, Houston, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Heart Association, Houston, April 27, 1953. Dr. J. C. Crager, Beaumont, Pres.; Miss Roberta Miller, 411 Reserve Loan Life Bldg., Dallas, Executive Secy.

Texas Hospital Association, Galveston, May 12-14, 1953. Mr. Carroll H. McCray, Tyler, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, Houston, April 27, 1953. Dr. Don Morris, Dallas, Pres.; Dr. John L. Otto, John Sealy Hospital, Galveston, Secy.

Texas Orthopedic Association, Houston, April 27, 1953. Dr. Felix Butte, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Corpus Christi, October, 1953. Dr. J. A. Bybee, Beaumont, Pres.; Dr. M. C. Carlisle, 1410 Austin Ave., Waco, Secy.

Texas Public Health Association, Galveston, Feb. 15-18, 1953. Mr. H. E. Drumwright, Dallas, Pres.; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Executive Secy.

Texas Radiological Society, San Antonio, Jan. 23-24, 1953. Dr. Robert D. Moreton, Fort Worth, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Houston, April 27, 1953. Dr. Everett Lewis, Houston, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association, Dallas, Dec. 5, 1952. Dr. Robert H. Mitchell, Fort Worth, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Austin, March 2-3, 1953. Mr. William Grant, Jr., Baytown, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 21, Executive Secy.

Texas Society of Anesthesiologists, Houston, April 27, 1953. Dr. John F. Winter, San Antonio, Pres.; Dr. C. R. Allen, John Sealy Hospital, Galveston, Secy.

Texas Society of Gastroenterologists and Proctologists, Houston, April 27, 1953. Dr. Jack Kerr, Dallas, Pres.; Dr. C. P. Hardwicke, 120 W. Seventh St., Austin, Secy.

Texas Society of Ophthalmology and Otolaryngology, Houston, Dec. 5-6, 1952. Dr. J. Charles Dickson, Houston, Pres.; Dr. Lyle Hooker, 627 Esperson Bldg., Houston, Secy.

Texas Society of Pathologists, Houston, Jan. 25, 1953. Dr. Charles T. Ashworth, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society, San Antonio, April 6-7, 1953. Dr. George W. Waldron, Houston, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Mineral Wells, April 9-11, 1953. Dr. David McCullough, Kerrville, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society. Dr. R. E. Cone, Galveston, Pres.; Dr. Roy M. Morgan, Jr., Hermann Hospital, Houston, Secy.

DISTRICT

First District Society, El Paso, Feb. 13-14, 1953. Dr. Jim Camp, Pecos, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society, Big Spring, April 3, 1953. Dr. John Hogan, Big Spring, Pres.; Dr. Arch Carson, Box 111, Big Spring, Secy.

Third District Society, Lubbock, April 14-15, 1953. Dr. James A. Odom, Memphis, Pres.; Dr. James T. Hall, 1626 Fifteenth Street, Lubbock, Secy.

Fourth District Society, Brownwood, Fall, 1953. Dr. Lloyd R. Hershberger, San Angelo, Pres.; Dr. Paul M. Wheelis, Brownwood, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 10-11, 1953. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. Robert J. Sigler, 1126 Third Street, Corpus Christi, Secy.

Seventh District Society, Austin. Dr. George W. Tipton, Austin, Pres.; Dr. D. B. Faubion, 1403-C Guadalupe, Austin, Secy.

Eighth District Society, Fall, 1953. Dr. Andrew S. Tomb, Victoria, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society, Baytown, April 1, 1953. Dr. Otto F. Schoenvogel, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. Peyton C. Clements, Lufkin, Pres.; Dr. Edmund D. Jones, 2575 South, Beaumont, Secy.

Eleventh District Society, Tyler, Spring, 1953. Dr. Roscoe Moore, Mineola, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society. Dr. J. B. Brown, Temple, Pres.; Dr. Neil D. Buie, Marlin, Secy.

Thirteenth District Society, Wichita Falls. Dr. R. E. Cowan, Graham, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy

Fourteenth District Society, Gainesville, June 9, 1953. Dr. W. P. Philips, Greenville, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Daingerfield, 1953. Dr. D. R. Baber, Daingerfield, Pres.; Dr. P. A. Reitz, Pittsburg, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 16-19, 1953. Miss Betty Elmer, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco. Dr. Walter B. King, 2320 Columbus Ave., Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 27-29, 1953. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, March 2-5, 1953. Dr. Woodard D. Beacham, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Sept. 16, 1953. Dr. C. H. Wilson, Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference. Mrs. Muriel R. Waller, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, Houston, 1953. Dr. C. A. Dwyer, Secy., 229 Medical Arts Bldg., Houston.

TEXAS SURGICAL SOCIETY

Dr. George W. Waldron, Houston, was elected president of the Texas Surgical Society during its semi-annual meeting held in Austin on October 6 and 7. Other officers elected were Drs. Harriss Williams, Austin, first vice-president; Hub E. Isaacks, Fort Worth, second vice-president; Albert W. Hartman, San Antonio, secretary; and Robert Sewell, Fort Worth, treasurer. Councilors chosen included Drs. Howard O. Smith, Marlin; Truman G. Blocker, Jr., Galveston; and C. B. Carter, Dallas.

Dr. Lawrence W. O'Neal, St. Louis, presented a paper on "The Surgical Treatment of Cushing's Syndrome," as prepared by Dr. Peter Heinbecker, St. Louis, special guest speaker who was unable to appear. Other papers presented included:

Anterior Mediastinal Transplantation of Jejunum and Cervical Esophagojejunostomy in Substitution for Esophagus—Dr. Donald Paulson, Dallas.

Lye Stricture of Thoracic and Cervical Portions of Esophagus Treated by Esophagectomy and Subpharyngeal Esophagogastrostomy; Report of 3 Cases—Dr. Clive R. Johnson, Fort Worth.

Simulation of Benign Pulmonary Disease by Malignant Lesions of Lung—Dr. G. V. Brindley, Jr., Temple.

Resection of Sacrum for Benign Giant Cell Tumor; Case Report—Dr. Robert Paul Hays, McKinney.

Reconstruction of a Severely Injured Forearm (motion picture by Dr. Raleigh R. White, Temple)—Dr. Robert Murray, Temple.

Liposarcoma—Dr. Porter Bailes, Jr., Tyler.

Panarteritis; Report of Occurrence in Twenty Year Old Female Resulting in Gangrene of Feet and Necessitating Bilateral Amputation of Legs—Dr. John M. Thiel, Galveston.

Brain Abscess in the Antibiotic Era—Dr. Ralph A. Munslow, San Antonio.

Endometrial Biopsy as a Standard Diagnostic Technique; Review of 445 Cases—Dr. John A. Wall, Houston.

Lymphangiosarcoma in Postmastectomy Lymphedema—Dr. Francis C. Usher, Houston.

Mammary Cancer Growth Characteristics; Observations Made During Treatment of 254 Private Patients with Breast Cancer—Dr. John V. Goode, Dallas.

Management of Tumors of Head and Neck: Case Reports—Drs. T. G. Blocker, Jr., C. C. Snyder, and Stephen Lewis, Galveston.

Surgical Treatment of Oomphalocele—Dr. J. Peyton Barnes, Houston.

Mesenteric Vein Thrombosis—Dr. C. D. Bussey, Dallas.

Giant Gastric Leiomyoma: Case Report—Dr. W. S. Lorimer, Jr., Fort Worth.

Blind Pouch as a Complication of Side-to-Side Intestinal Anastomosis—Dr. James E. Pittman, Houston; Dr. Ray Cruse, Houston; and Dr. J. D. Morris, Galveston.

Massive Upper Gastrointestinal Hemorrhage of Indeterminate Origin—Dr. L. L. D. Tuttle, Houston.

The scientific sessions of the program were held at the Commodore Perry Hotel and in the auditorium of the Texas Medical Association's building. The next meeting will be held April 6 and 7 in San Antonio. Dr. Edward W. Coyle, San Antonio, is the chairman of the local arrangements committee.

SOUTHWESTERN MEDICAL SCHOOL

Recent grants received by the Southwestern Medical School of the University of Texas in Dallas include:

From the Dallas Heart Association, $13,500 for research in cardiovascular diseases.

From the Florence and Irv Walls Foundation, Incorporated, $1,000 for research in the Department of Surgery, under the direction of Dr. W. D. Weary.

From the United States Public Health Service for the period from April 1, 1953, through March 31, 1954, $6,642 for research under the direction of Dr. Donald Seldin.

Dr. Don Morris, professor of neuropsychiatry, has been elected a charter member of the American Academy of Child Psychiatry.

Dr. Gilbert B. Forbes, professor and chairman of the Department of Pediatrics, participated in the meeting of pediatric educators held in New Orleans on November 8.

S. Edward Sulkin, Ph. D., professor and chairman of the Department of Bacteriology, presided at a virus disease session of the annual meeting of the American Public Health Association in October. He also presented a paper on "Developments in the Diagnosis of Virus Disease." In addition, Dr. Sulkin spoke on "The Influence of Urethame on Susceptibility of Adult Mice to the Coxsackie Virus" at the meeting of the Texas Branch of the Society of American Bacteriologists, held in Austin on October 31.

Dean G. N. Aagaard and Assistant Deans John Chapman and Robert Lackey attended the meeting in Colorado Springs from November 9 to 12 of the Association of American Medical Colleges. Dean Aagaard is chairman of the Association's committee on continuation education.

Dr. William F. Mengert, professor and chairman of the Department of Obstetrics and Gynecology, presented a paper entitled "Acute Hypertension in Pregnancy" at the first annual meeting of the American Academy of Obstetrics and Gynecology which was held in Chicago, December 15 through 17. Dr. Mengert is a member of the Board of Governors of the Academy and is one of the associate editors of the Academy's new journal, *Obstetrics and Gynecology.*

International Medical Assembly

Sixteen guest speakers will take part in the annual midwinter meeting in San Antonio January 27-29 of the International Medical Assembly of Southwest Texas. The general sessions will be held on January 27; in addition, a clinical pathological conference is also scheduled for this date. Symposiums on cervical carcinoma, bone tumors, shock and resuscitation, and vascular disease will be conducted on January 28 and 29.

Guest speakers include Col. James E. Ash, Suburban Hospital, Bethesda, Md.; Dr. Alfred Blalock, professor of surgery, Johns Hopkins University School of Medicine, Baltimore; Dr. Edgar Burns, professor of urology, Tulane University School of Medicine, New Orleans; Dr. J. Lamar Callaway, professor of dermatology and syphilology, Duke University School of Medicine, Durham, N. C.; Dr. Bradley L. Coley, associate professor of clinical surgery, Cornell University Medical College, New York; Dr. Samuel A. Cosgrove, clinical professor of obstetrics, Columbia University College of Physicians and Surgeons, New York; Dr. Paul H. Holinger, associate professor of otolaryngology, University of Illinois College of Medicine, Chicago; Dr. John F. Holt, associate professor of roentgenology, University of Michigan Medical School, Ann Arbor; Dr. Phillip Robb McDonald, assistant professor of ophthalmology, Graduate School, University of Pennsylvania School of Medicine, Philadelphia; Dr. Joe Vincent Meigs, clinical professor of gynecology, Harvard Medical School, Boston; Dr. Ovid O. Meyer, professor of medicine, University of Wisconsin Medical School, Madison; Dr. Alton Ochsner, professor of surgery, Tulane University School of Medicine, New Orleans; Dr. David I. Rutledge, Department of Medicine, Lahey Clinic, Boston; Dr. Hans Selye, professor of experimental medicine and surgery, University of Montreal Faculty of Medicine, Montreal; Dr. Ralph M. Tovell, chief, Department of Anesthesiology, Hartford Hospital, Hartford, Conn.; and Dr. James L. Wilson, professor of pediatrics and community diseases, University of Michigan Medical School, Ann Arbor.

A general luncheon, stag party, dinner-dance, and sectional luncheons are other features of the meeting. The all-inclusive registration fee will be $20. Requests for further information and advance registrations may be addressed to Post Office Box 2445, San Antonio.

Medical Education Amendment Adopted

When the Texas voters went to the polls on November 4 to elect the next president and vice-president of the United States, they also voted on two proposed amendments to the Texas constitution, one of which was related to medicine. As a result of the record vote in the state, the amendment known as the Medical Education Fund Amendment was passed by a vote of 544,046 to 535,891.

The amendment, known as House Joint Resolution 38, for which the voters cast their ballots adds a new Section 50a to Article III of the Constitution. It reads as follows: "The Legislature shall create a state medical education board to be composed of not more than six members whose qualifications, duties, and terms of office shall be prescribed by law. The Legislature shall also establish a state medical education board to provide grants, loans, or scholarships to students desiring to study medicine and agreeing to practice in the rural areas of this state upon such terms and conditions as shall be prescribed by law. The term 'rural areas' as used in this section shall be defined by law."

The adoption of this amendment will necessitate enabling legislation, which will be considered by the next Legislature when it convenes in January.

PERSONALS

Dr. G. V. Brindley, Sr., Temple, has been elected to the Board of Regents of the American College of Surgeons, according to the Elgin *Courier.*

Dr. John Potts, Fort Worth, author of several books, has recently written another entitled "Look in Your Mirror," reports the Fort Worth *Star-Telegram.* Dr. Potts's new work is a handbook for self-psychoanalysis and self-treatment of personality problems.

Dr. Mary Ruth Jackson, Dallas, has been elected president of the grand chapter of Alpha Epsilon Iota fraternity, whose thirty chapters throughout the United States are composed of women medical students, according to the Dallas *Times Herald.*

Mrs. Iona (Kearse) Young, wife of *Dr. James W. Young, Sr.,* of Sweetwater, died October 4, states the Abilene *Reporter-News.* Two sons, *Dr. Tom D. Young* and *Dr. James W. Young, Jr.,* both of Sweetwater, survive their mother, as does a daughter, Mrs. Sterling Childress of Abilene.

Recent births reported by the *Alumni Bulletin* of the University of Texas Medical Branch include boys to *Mr. and Mrs. Charles (Dr. Eva) Everett,* Galveston; *Dr. and Mrs. Harold T. Pruessner,* Corpus Christi; and *Dr. and Mrs. William L. Carrington,* Mexia; and a girl to *Dr. and Mrs. George F. Eden,* Houston. Other births accounted in the newsletter of the Tarrant County Auxiliary are boys to *Dr. and Mrs. John B. Fershtand* and *Dr. and Mrs. Forest C. Barber* of Fort Worth. In addition, the Bexar County Auxiliary reports the recent birth of children to *Dr. and Mrs. William J. Block, Jr., Dr. and Mrs. Ernest G. Guy, Dr. and Mrs. C. Ralph Letteer, Jr., Dr. and Mrs. Nathaniel G. Tippet, Dr. and Mrs. S. P. Zeitlin, Dr. and Mrs. David M. Keedy, Dr. and Mrs. John M. Smith, Jr.,* and *Dr. and Mrs. Sidney L. Stovall,* all of San Antonio.

CORRECTION: DOCTOR-DRAFT PROBLEMS

The following portion of a news item "Doctor-Draft Problems," appearing on page 778 of the November JOURNAL, is incorrect: "If a registrant refuses to sign a waiver, the Armed Forces will not accept him for commission; this is authority for a local board to classify him 4-F as a special registrant."

Under Public Law 779, special registrants with waivable physical defects will be inducted as enlisted men if they fail to request a waiver when applying for commission. On the other hand, special registrants with physical defects which are not waivable will be considered physically disqualified for military service; the latter group will then be entitled to 4-F classification.

NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The sixteenth annual meeting of the New Orleans Graduate Medical Assembly will be held March 2 to 5 when eighteen guest speakers will participate in a program designed for specialists and general practitioners.

Included in the program will be demonstrations of medical and surgical procedures in color television, clinicopathologic conferences, medical motion pictures, technical exhibits, and round-table luncheons.

A postclinical meeting tour has been planned and participants will leave March 7 from New York for a trip to England, France, Switzerland, and Italy with medical programs in each country. Details of the meeting in New Orleans and the tour to Europe can be obtained from the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12.

Industrial Medicine Fellowships

The Institute of Industrial Health of the University of Cincinnati College of Medicine is accepting applications for a limited number of fellowships offered to qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of industrial medicine. Any registered physician who is a graduate of a class A medical school and who has satisfactorily completed at least two years of training in a hospital accredited by the American Medical Association may apply. Requests for additional information may be addressed to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19.

Education Foundation Memorial Gifts

The American Medical Education Foundation is ready to accept memorial gifts from persons who wish to honor the deceased. A bulletin from the Foundation states that all such gifts received will be acknowledged to the donors and notice of receipt will also be sent to the immediate survivors of the deceased. The Foundation's total income to date is $782,000 from 5,100 contributors.

LIBRARY SECTION

PACKAGE SERVICE

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Request for packages should be addressed "Library, Texas Medical Association, 1801 Lamar Boulevard, Austin, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Packages are allowed to remain in the hands of the borrower for 14 days.

ACCESSIONS

The following additions were made to the Library during November:

Reprints received, 1,150.

Journals received, 290.

Books received, 22.

Bacterial and Mycotic Infections of Man, ed. 2, Dubos (editor); *Viral and Rickettsial Infections of Man,* ed. 2, Rivers (editor); *Transactions of the Southern Surgical Association,* vol. 63, 1951, Burch (editor), J. B. Lippincott, Philadelphia.

Monographs in Medicine, Bean (editor), Williams and Wilkins Company, Baltimore.

Opiate Addiction, Wikler; *Oestrogens and Neoplasia,* Burrows and Horning, Charles C. Thomas, Springfield, Ill.

Practical Dermatology, Lewis; *Diseases of Metabolism,* ed. 3, Duncan (editor); *Ophthalmic Pathology,* Friedenwald and others; *Nutrition and Diet in Health and Disease,* ed. 6, McLester and Darby; *Electrocardiography in Practice,* ed. 3, Graybiel and others; *Standard Values in Blood,* Albritton, W. B. Saunders Company, Philadelphia.

Advances in Internal Medicine, vol. 5, Dock and Snapper (editors); *Year Book of Medicine* 1952, Beeson (Editor); *Year Book of Radiology,* 1952, Hodges (editor); *Year Book of General Surgery,* 1952, Graham (editor); *Year Book of Obstetrics and Gynecology,* 1952, Greenhill (editor), Year Book Publishers, Chicago.

Health Resources in the United States, Bachman, Brookings Institute, Washington, D. C.

Publications from the Division of Surgery of Northwestern University Medical School, vol. 16, 1951-1952, Chicago.

The Low Fat Diet Cook Book, Hildreth and Hildreth, Medical Research Press, New York.

Text-Book of Ophthalmology, vol. 5, Duke-Elder; *The Thyroid,* McGavack, C. V. Mosby Company, St. Louis.

Malaria, Russell, Blackwell Scientific Publications, Oxford.

SUMMARY OF SERVICE

Local users, 78.	Borrowers by mail, 52.
Local packages, 31.	Packages mailed, 68.
Films loaned, 88.	

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films in the hands of the borrower.

Request for films should be addressed to "Motion Picture Film Library, Texas Medical Association, 1801 Lamar Boulevard, Austin, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion pictures were loaned by the Library during the month of November:

Allergy (Mead Johnson)—Southwestern Pre-Medical Association, Georgetown.

Anesthesia, Low Spinal (Modified Saddle Block) in Obstetrics (Ciba Pharmaceutical Products)—Mitchell Clinic, McKinney; Brackenridge Hospital, Austin; Ballinger Clinic Hospital, Ballinger; and Central Texas Chapter, American Academy of General Practice, Waco.

Anesthesia, Regional (Winthrop-Stearns)—Pre-Medical Club, Baylor University, Waco.

Anesthesia with Vinethene (Merck and Company)—Central Texas Chapter, American Academy of General Practice, Waco.

Appraisal of the Newborn (Mead Johnson)—Brackenridge Hospital School of Nursing, Austin, and Vocational Nurses School, Calhoun County Memorial Hospital, Port Lavaca.

Ascorbic Acid and Scurvy (Mead Johnson)—McKnight Sanatorium School of Nursing, Sanatorium.

Aureomycin, The Versatile Antibiotic (Lederle Laboratories)—Travis County Laboratory Technicians, Austin, and University of Houston Pharmacy Department, Houston.

Behind the Shadows (Texas Tuberculosis Association)—University of Houston Pharmacy Department, Houston.

Bleeding Tendency, Methods for Determination of (Mead Johnson)—Scott and White Memorial Hospitals School of Nursing, Temple.

Blood Transfusion, Technique of (Mead Johnson)—Scott and White Memorial Hospitals School of Nursing, Temple.

Breast Cancer: The Problem of Early Diagnosis (American Cancer Society)—Kaufman County Medical Society, Terrell.

Breech Extraction with Forceps (Mead Johnson)—Swanson Clinic and Hospital, Taylor.

Cancer: The Problem of Early Diagnosis (American Cancer Society)—Dr. Paul Katribe, McAllen.

Cerebral Palsy, Treatment, Training, and Education (Dr. Herbert Hipps)—Austin State School Employees, Austin.

Cesarean Section, Low Cervical (Mead Johnson)—Swanson Clinic and Hospital, Taylor.

Child Study: Life History of Mary (Dr. Margaret Fries)—Stephenville Hospital and Clinic, Stephenville.

Coarctation of the Aorta, Surgical Treatment for (Dr. Philip Thorek)—Alpha Epsilon Delta, University of Texas, Austin.

Coming Home (Texas Tuberculosis Association)—Dr. John M. Travis, Wills Point.

Conquering Darkness (Hurst Eye, Ear, and Throat Clinic)—Rotary Club, Dallas.

Delivery of Triplets (Ciba Pharmaceutical Products)—Stephenville Hospital and Clinic, Stephenville, and Brackenridge Hospital School of Nursing, Austin.

Diagnosis of Poliomyelitis (National Foundation for Infantile Paralysis)—Travis County Laboratory Technicians, Austin, and Hidalgo-Starr Counties Medical Society, McAllen.

Diphtheria and Croup (Lederle Laboratories)—Swanson Clinic and Hospital, Taylor.

The Doctor Speaks His Mind (American Cancer Society)—Swanson Clinic and Hospital, Taylor, and Henderson County Medical Auxiliary, Athens.

Dwarfism (Mead Johnson)—Brackenridge Hospital School of Nursing, Austin.

Dysmenorrhea, Primary (G. D. Searle and Company)—Loretto Hospital Staff, Dalhart.

Edema, Cardiac and Renal (Winthrop-Stearns)—Brackenridge Hospital School of Nursing, Austin.

Eyes for Tomorrow (Hurst Eye, Ear, and Throat Clinic)—Lions Club, Robstown.

Eyes, Your Children's (British Information Services)—Parent-Teachers Association, Whitney.

Feeding the Infant during the First Year (Mead Johnson)—Vernon Clinic, Vernon.

Functional Anatomy of the Hand (National Foundation for Infantile Paralysis)—Arlington State College Pre-Medical Club, Arlington; Baylor Hospital School of Physical Therapy, Dallas; and Brackenridge Hospital School of Nursing, Austin.

Gastro-Intestinal Cancer: The Problem of Early Diagnosis (American Cancer Society)—Hidalgo-Starr Counties Medical Society, McAllen.

Glaucoma Operations (Dr. Ray K. Daily)—Nueces Eye, Ear, Nose, and Throat Society, Corpus Christi.

Goiter Surgery (Mead Johnson)—Dr. Fred G. Lahourcade, San Antonio, and Scott and White Memorial Hospitals School of Nursing, Temple.

The Heart: Cardiovascular Pressure Pulses and Electrocardiography (G. D. Searle and Company)—Ghormley Clinic Hospital Medical Staff, Corpus Christi, and Albert Clinic, San Antonio.

The Heart: Electrokymography, Venous Catheterization and Angiocardiography (G. D. Searle and Company)—Ghormley Clinic Hospital Medical Staff, Corpus Christi, and Albert Clinic, San Antonio.

Heart Disease, Oxygen Therapy in (Linde Air Products)—West Texas Hospital and Clinic, Lubbock; Porter Clinic, Lubbock; and Tahoka Hospital and Clinic, Tahoka.

Immunization Against Infectious Diseases (Lederle Laboratories)—Parent-Teachers Association, Whitney.

Infantile Paralysis, Your Fight Against (National Foundation for Infantile Paralysis)—Parent-Teachers Association, Whitney.

Malaria (British Information Services)—University of Houston Pharmacy Department, Houston.

Modern Nutrition (E. R. Squibb and Company)—Scott and White Memorial Hospitals School of Nursing, Temple, and McKnight Sanatorium School of Nursing, Sanatorium.

Normal Delivery (Mead Johnson)—Swanson Clinic and Hospital, Taylor, and Calhoun County Memorial Hospital Vocational Nursing School, Port Lavaca.

On Our Own (National Foundation for Infantile Paralysis)—Lions Club, Robstown, and Gonzales High School, Gonzales.

Oxygen Therapy Procedures (Linde Air Products)—West Texas Hospital and Clinic, Lubbock; Porter Clinic, Lubbock; and Tahoka Hospital and Clinic, Tahoka.

Pneumonia (Mead Johnson)—Austin State School Attendants, Austin.

Polio—Diagnosis and Management (British Information Services)—12th and 27th Medical Groups, Bergstrom Air Force Base.

Pregnancy, Multiple (Mead Johnson)—Mitchell Clinic, McKinney.

Premature Infant, Care of (Mead Johnson)—Calhoun County Memorial Hospital Vocational Nursing School, Port Lavaca.

Proof of the Pudding (Metropolitan Life Insurance Company)—Stephenville Grammar School, Stephenville, and Stephenville Hospital and Clinic, Stephenville.

Pyloric Stenosis, Congenital, Surgical Treatment for (Dr. Philip Thorek)—Stephenville Hospital and Clinic, Stephenville.

A Question in Time (American Cancer Society)—Dr. John M. Travis, Wills Point.

Resuscitation of the Newborn (Mead Johnson)—Brackenridge Hospital School of Nursing, Austin.

Roentgen Pelvimetry (Mead Johnson)—Dr. Arthur J. Barnett, Monahans.

Scabies (British Information Services)—Brackenridge Hospital School of Nursing, Austin.

Scarlet Fever (Lederle Laboratories)—Brackenridge Hospital School of Nursing, Austin.

Skin Grafting of Extensive Burns (Eaton Laboratories)—Dr. Arthur J. Barnett, Monahans, and Brackenridge Hospital School of Nursing, Austin.

Spontaneous Delivery (Mead Johnson)—Mitchell Clinic, McKinney.

A Stitch in Time (American Medical Association)—Shiner Rotary Club, Shiner.

Sulfonamide Therapy (Lederle Laboratories)—University of Houston Pharmacy Department, Houston.

TB, This Is (Texas Tuberculosis Association)—Parent-Teachers Association, Whitney.

Tuberculosis, Role of the Public Health Nurse in (Texas Tuberculosis Association)—University of Houston Pharmacy Department, Houston.

Uterosalpingography (E. Fougera and Company)—Dr. John M. Miles, Baytown.

Uterosalpingography, Serial (E. Fougera and Company)—Dr. John M. Miles, Baytown.

Varicose Veins and Their Complications (Becton, Dickinson and Company)—Ballinger Clinic-Hospital, Ballinger.

Vitamins and Some Deficiency Diseases (Lederle Laboratories)—University of Houston, Houston.

What Is Cancer? (American Cancer Society)—Austin State School, Austin.

You Can Help (Texas Tuberculosis Association)—Shiner Rotary Club, Shiner.

BOOK NOTICES

Correction: A Collection of Early Obstetrical Books

The notice of a book entitled "A Collection of Early Obstetrical Books," published by the author, Dr. Alfred M. Hellman of New York, which appeared on page 783 of the November JOURNAL incorrectly stated the cost of the book to be $2. The volume is being distributed by Dr. Hellman without charge.

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[1]The Treatment of Injuries to the Nervous System

DONALD MUNRO, M. D., F.A.C.S., *Surgeon-in-Chief, Department of Neurosurgery, The Boston City Hospital; Associate Professor of Neurosurgery, Boston University School of Medicine; Assistant Professor of Neurosurgery, Harvard University Medical School. 284 pages. $7.50. Philadelphia, W. B. Saunders Company, 1952.*

This book represents an excellent treatise on the management of injuries to the nervous system. It is readable and easy to understand. It covers the various managements of these conditions in detail. The book is written chiefly for a general practitioner and general surgeon. The outline of treatment it proposes will serve as a rational guide in the management of the various types of injuries to the nervous system. Most of the author's ideas represent the well-known and orthodox principles in handling these cases.

There are some features in which one cannot readily agree with the author, especially with regard to the management of head injuries, for which he advocates bed rest for such a long period of time. Another is the use of tracheotomy in the acute head injuries. The experience of many surgeons certainly justifies its use even though this author strongly condemns it. Anyone with normal intelligence can be taught in a few moments how to keep the air passages clear with the use of a tracheotomy thus proving it a life-saving measure.

Dr. Munro's idea on treatment of the early and late quadriplegic is excellent and should serve as a useful guide in the management of this type of injury, particularly the rehabilitation of these cases, which is a point so generally misunderstood. So often some of these patients can be rehabilitated and become self-sustaining individuals if they have the proper management early in the course of the trauma.

An interesting feature of this book is that it brings out the responsibility of the layman in the rehabilitation of the injured. It outlines his responsibility as well as the physician's.

In general this is a well-written book and should receive wide acceptance by the general practitioner and the general surgeon who are the first ones to see the vast majority of the injuries to the nervous system.

[2]Diseases of the Nervous System

F. M. R. WALSHE, M. D., D. Sc., F.R.S., *Fellow of the Royal College of Physicians of London; Fellow of University College, London; Consulting Physician to University College Hospital, and to the National Hospital for Nervous Diseases, Queen Square. Seventh edition. 365 pages. $5.50. Baltimore, The Williams and Wilkins Company, 1952.*

In his prefaces the author has described his purpose of presenting neurology to the student and general practitioner as a narrative account of the development of the patient's symptoms rather than as a static catalogue of localizing signs. For the most part he has succeeded in his purpose, and the text is interesting and understandable and gives the reader a picture of the patient as a human being with problems that are explainable on the basis of physiologic, anatomic, and temporal factors. The therapeutic suggestions consequently are practical and of a type likely to be acceptable to the average patient, though the suggestions are not elaborated sufficiently to give the practitioner a wide range of choice in therapy.

In general this a well-written book and should receive shortening of some sections, such as those dealing with anatomic descriptions, syndromes due to vascular disorders, epilepsy and epileptic equivalents, exogenous intoxications, psychoneurosis, and bibliography.

The book is well-conceived and well-written, and the reader probably will wish that an author of Walshe's caliber and competence had made his book more voluminous.

[3]Roentgenology in Obstetrics and Gynecology

WILLIAM SNOW, M. D., *Chief Radiologist, Veterans Hospital; Consulting Radiologist, Willis-Knighton Memorial Hospital and Clinic, Shreveport; Formerly Director of Roentgenology, The Harlem Hospital, The Bronx Hospital, New York City. First edition. 363 pages, $10.50. Springfield, Ill., Charles C. Thomas, 1952.*

The book consists of an excellent review of all acceptable procedures and techniques used in roentgenology as applied to obstetrics and gynecology. The obstetrical section was, in the opinion of the reviewer, of greater value and has more practical application than the section on gynecology. The description of all pelvimetry techniques and comparisons of them is extremely interesting, and since it is all in one text, it is more readily available to practitioners than anything we have had heretofore. Dr. Snow's own method of roentgenray pelvimetry and the clear manner in which both technique and interpretation are described will be of great aid in making the procedure available to more men. The book is well illustrated and, unlike most texts, stresses the more important complications, with less weight being placed on the rare and unusual. The section on gynecology is interesting and presents many ideas and helpful aids in diagnosis which are not in use generally today. The book is well worth reading, both to the man who limits his practice and to the general practitioner.

[4]Diseases of the Nervous System in Infancy, Childhood and Adolescence

FRANK R. FORD, M. D., *Associate Professor of Neurology. The Johns Hopkins University, Baltimore. Third edition. 1,181 pages. $18.50. Springfield, Ill., Charles C. Thomas, 1952.*

This book represents a complete detailed study of the neurologic problems of infancy, childhood, and adolescence. The illustrations are of the highest quality. It is noteworthy that the author expends considerable space and time on treatment and prognosis.

Chapter 3, "Prenatal and Developmental Defects of the Nervous System"; chapter 5, "Infections and Parasitic Invasions of the Nervous System"; chapter 6, "Toxic and Metabolic Disorders Involving the Nervous System"; and chapter 9, "Injuries of the Nervous System by Physical Agents" are outstanding in their information and thoroughness.

I recommend this book to pediatricians and neurologists.

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[1]*W. A. Jones, M. D., El Paso.*
[2]*Melbourne J. Cooper, M. D., San Antonio.*
[3]*M. D. McCauley, M. D., Austin.*
[4]*W. Price Killingsworth, M. D., Port Arthur.*

Standard Values in Blood

Edited by ERRETT C. ALBRITTON, A. B., M. D., *Fry Professor of Physiology, The George Washington University. 119 pages. $4.50. Philadelphia, W. B. Saunders Company, 1952.*

This is the first fascicle of a handbook of biological data prepared under the direction of the Committee on the Handbook of Biological Data of the American Institute of Biological Sciences of the National Research Council.

[5]**Surgery of the Chest—A Handbook of Operative Surgery**

JULIAN JOHNSON, M. C., D. Sc. (Med.), *Professor of Surgery, School of Medicine and Graduate School of Medicine, University of Pennsylvania, and* CHARLES K. KIRBY, M. D., *Assistant Professor of Surgery, School of Medicine, University of Pennsylvania. Illustrated by* EDNA HILL. *387 pages. $9. Chicago, Year Book Publishers, 1952.*

The authors state that the book is "primarily an atlas of thoracic surgical operations," and the format follows this objective in a faithful manner. The numerous illustrations are excellent and are exceptionally well correlated with the annotations in the text. The illustrations pertaining to operative procedures portray anatomic detail accurately and at the same time are not diagramatic in appearance.

In addition to the anatomic details illustrated in the various operative procedures, a special section of the book is devoted to surgical anatomy of the lungs. In this brief section, all the essential knowledge pertaining to this subject is organized and presented in an exceptionally clear manner. As the authors point out, "The anatomic information which the thoracic surgeon should have at his finger-tips does not appear in standard anatomy text books." Although nothing new is described in the section on surgical anatomy, I doubt that this compilation of anatomic data is available from any other single source in the literature.

The authors' discussions of related physiology, diagnosis, and preoperative and postoperative care are of considerable importance in this book and certainly take the book out of the class of a mere atlas of operative procedures. These discussions are brief but are full of practical details of the sort one usually has to learn from long and frequently bitter experience.

This admirable little book fills a long-felt need in the field of thoracic surgery. The authors have indeed provided "all the information needed by those with a background in general surgery who wish to learn the technique of thoracic surgical procedures." I think that any well-trained thoracic surgeon would welcome having this book. It probably will prove of greatest value to residents in training in thoracic surgery.

[5]*Samuel H. Haigler, M. D., Wharton.*

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

Annual Congress on Industrial Health

The Council on Industrial Health of the American Medical Association will sponsor the thirteenth annual Congress on Industrial Health to be held on January 21 and 22. One session of the meeting will endeavor to answer the question of how management, labor, and medicine can best help maintain the health of the national work force. On January 20, one day before the Congress convenes, a joint conference will be held for members of the council and chairmen of state society committees on industrial health.

TEXAS MEDICAL ASSOCIATION

ANNUAL SESSION SPEAKERS

More than thirty out-of-state physicians who are native Texans or who received their medical training in Texas have accepted the Texas Medical Association's invitation to participate in celebration of the centennial anniversary of the establishment of a medical organization in this state at the 1953 annual session in Houston April 26-29.

A tentative list of the former Texans and the section before which they will speak includes the following:

Dr. Lucian W. Alexander, New Orleans, eye, ear, nose and throat.
Dr. Cornelius C. Bailey, Los Angeles, radiology.
Dr. Julia Baker, Mexico, pediatrics.
Dr. Nicholas L. Ballich, Baltimore, general practice.
Dr. Jere M. Bauer, Ann Arbor, internal medicine.
Dr. J. C. Cain, Rochester, Minn., general practice.
Dr. Grayson Carroll, St. Louis, general practice.
Dr. Roy L. Cleere, Denver, public health.
Dr. Mandred W. Comfort, Rochester, Minn., internal medicine.
Dr. Cyril Costello, St. Louis, general practice.
Dr. John Ellis, New York, clinical pathology.
Dr. Ralph Gause, New York, obstetrics and gynecology.
Dr. Wendell C. Hall, Hartford, Conn., radiology.
Dr. Aubrey O. Hampton, Washington, D. C., radiology.
Dr. Harry Hauser, Cleveland, radiology.
Dr. Henry A. Holle, New York, public health.
Dr. Joseph V. Hopkins, New Orleans, radiology.
Dr. William L. Howell, Washington, D. C., internal medicine.
Dr. John C. King, Memphis, radiology.
Dr. Conrad Lam, Detroit, surgery.
Dr. Walter H. Maloney, Philadelphia, eye, ear, nose and throat.
Dr. Oliver S. Moore, New York, general practice.
Dr. Winn Sherrill, La Jolla, Calif., pediatrics.
Dr. Charles C. Sprague, New Orleans, internal medicine.
Dr. Paul R. Streit, Washington, D. C., eye, ear, nose, and throat and public health.
Dr. W. S. Thomas, Rochester, N. Y., clinical pathology.
Dr. James E. Thompson, New York, surgery.
Dr. W. D. Tigertt, Washington, D. C., clinical pathology.
Dr. M. L. Trumbull, Memphis, clinical pathology.
Dr. B. B. Wells, Little Rock, clinical pathology.
Dr. Chris J. Zarafonetis, Philadelphia, internal medicine.

In addition to this list a special guest of the Association will be Dr. Francis F. Rosenbaum, Milwaukee, who will speak before the Section on Obstetrics and Gynecology and at the Tuesday morning general meeting.

Dr. P. I. Nixon, San Antonio, whose book on the history of the Texas Medical Association will be published in the spring, will speak at the opening exercises of the annual

session. Several distinguished men of medicine have been invited to present reviews of the medical progress of each medical specialty within the past hundred years and especially of progress in Texas and by Texans. These papers will be given by Dr. J. M. Travis, Jacksonville, general practice; Chauncey D. Leake, Ph.D., Galveston, internal medicine; Dr. Willard R. Cooke, Galveston, obstetrics and gynecology; Dr. G. V. Brindley, Temple, surgery; Dr. E. H. Cary, Dallas, eye, ear, nose and throat; Dr. R. T. Wilson, Austin, radiology; Dr. C. L. Williams, Beaumont, public health; Dr. B. F. Stout, San Antonio, clinical pathology; and Dr. Frank H. Lancaster, Houston, pediatrics.

Members of the Association who desire to submit a paper for the program should write immediately to the chairman or secretary of the appropriate section giving the topic and a résumé of the paper. Section programs will be closed in mid-January when all papers will be submitted for review at a meeting of the Council on Scientific Work. Names of the officers of the scientific sections appear on page 411 of the June JOURNAL.

Telephone Broadcasts Begin in February

The first in the series of four telephone broadcasts to be held during 1953 under the sponsorship of the Council on Medical Education and Hospitals of the Texas Medical Association is scheduled for February 10, and county medical societies which wish to take advantage of the postgraduate programs should be making their arrangements to assure completion of the necessary technical details, Dr. Milford O. Rouse, Dallas, chairman of the council, points out.

The February program will be on "Peptic Ulcer—Modern Concepts" with Dr. Tate Miller, Dallas, as moderator. Other programs in the series are for March 10, "Poliomyelitis—Evaluation of Present Status," Dr. J. M. Coleman, Austin, moderator; October 13, "Practical Management of More Frequent Obstetric Emergencies," Dr. William F. Mengert, Dallas, moderator; and November 10, "Use and Abuse of Antibiotics," Dr. James Kreisle, Austin, moderator.

A contact man should be appointed by each county society or hospital staff desiring to participate in the telephone programs, Dr. Rouse states. His name and the exact meeting place of each group should be reported to the Executive Secretary of the Association at the earliest possible time, and in no instance later than January 15 for the first two programs. The contact man should arrange with the manager of the local telephone company for a line to be run from the telephone exchange to the meeting place and with a local radio station or dealer in electronic equipment for installation of an amplifier in the meeting place. The Executive Secretary will arrange for a long distance hook-up to each participating city from Austin, where each of the programs will originate.

Although the exact cost to each participating society has not been determined, it is expected that a $10 (plus 25 per cent tax) "booster charge" to relay the program from one town to the next, charges by the local telephone company for connecting the meeting place to the telephone exchange, and rental of an amplifier should cover the expense for each program.

A special subcommittee of the Council on Medical Education and Hospitals is directing the telephone postgraduate broadcast series. Headed by Dr. Joseph Kopecky, San Antonio, the committee also includes Drs. Charles T. Stone, Galveston; Henry M. Winans, Dallas; Mavis P. Kelsey, Houston; James D. Murphy, Fort Worth; Raleigh R. Ross, Austin; and Asher R. McComb, San Antonio.

Final technical details regarding the telephone network will be worked out by late December and full information will be mailed to each county society.

Inactive and Honorary Membership Facts

County society presidents and secretaries and district councilors are reminded that a new classification of membership in the Association, inactive membership, was authorized by the House of Delegates at its last session. Nominations for inactive membership already have been received in the central office and will be accepted until time for the 1953 annual session.

Final action on physicians nominated either to inactive or to honorary membership after the 1952 session cannot be taken until the House of Delegates meets in April, 1953, at which time the physician's current regular dues of $50 must be paid. The new rate in dues ($4 for either honorary or inactive membership) for a physician elected to a new membership status will not become effective until January 1 of the year following his election by the House of Delegates. No provision is made for refunding a portion of regular dues to members subsequently elected to honorary or inactive membership.

Clarification of the rules regarding inactive and honorary membership was made recently in a letter to county society officers in preparation for payment of dues for 1953, which should be in the hands of the Executive Secretary by January 1, the opening of the next membership year. Statements in the letter and in the preceding paragraph were authorized by the Board of Trustees acting upon the advice of the legal counsel of the Association.

Some points with respect to American Medical Association dues for 1953 also might be reviewed. Dues in the A. M. A. are $25 yearly; fellowship dues have been eliminated. Membership may be maintained without payment of dues by physicians classified as follows:

1. Members who are 70 years of age or older and who request exemption from paying dues.
2. Members temporarily in the armed forces, regardless of local dues exemptions.
3. Interns and residents for five years after graduation. (Time spent in military service may be excluded in counting the five year limit.)
4. Members retired from active practice provided they are fully or partially excused from payment of local and state dues.
5. Members whose county society secretaries can verify that payment of dues would work a financial hardship and who are excluded in full or part from payment of local dues.

Application blanks for membership in the Texas Medical Association are available upon request to the central office.

NIXON BOOK TO BE PUBLISHED

The Board of Trustees of the Texas Medical Association has announced that final plans for the publication of the history of the Texas Medical Association during the past one hundred years by Dr. P. I. Nixon of San Antonio, have been completed and the book will be off the press before the annual session in April, 1953.

Containing 500 pages with twenty-four pages of illustrations, "The History of the Texas Medical Association" will be published by the University of Texas Press in Austin and copies of the history will be available at the centennial observance of the establishment of the State Association at the annual session in Houston, April 26-29. Promotion and publicity for the book will be handled by the University of Texas Press.

Dr. Nixon is also the author of two other books, "The Medical Story of Early Texas 1528-1853" and "A Century of Medicine in San Antonio."

COUNTY SOCIETIES

Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts Ochiltree-Hutchinson-Carson Counties Society

October 16, 1952

(Reported by Malcolm H. Wyatt, Secretary)

Panel Discussion—Denton A. Cooley, Houston, moderator.
Status of Supervoltage Roentgen-Ray Therapy—Vincent P. Collins, Houston.
Radioactive Iodine in Diagnosis and Treatment of Thyroid Tumors—Herbert C. Allen, Jr., Houston.
Treatment of Malignant Blood Dyscrasias and Lymphomas—Robert A. Hettig, Houston.
Management of Carcinoma of the Breast with Metastases (Hormones)—Dr. Cooley.

Held in Pampa on October 16, the annual meeting of District Three, Texas Division of the American Cancer Society supplanted the regular monthly meeting of the Gray - Wheeler - Hansford - Hemphill - Lipscomb - Roberts-Ochiltree-Hutchinson-Carson Counties Medical Society. Harvey H. Latson, Amarillo, introduced Dr. Cooley of Houston, who was moderator for the panel discussion outlined above.

Hardeman-Cottle-Foard-Motley Counties Society

October 23, 1952

(Reported by J. M. Taylor, Secretary)

Discussion of Injuries Involving the Hip—George W. Horton, Wichita Falls.

The Hardeman-Cottle-Foard-Motley Counties Medical Society met in Quanah on October 23. After dinner, J. F. Hughes of Spur, president, presided over the business session and introduced the guest speaker.

Milam County Society

October, 1952

The October meeting of the Milam County Medical Society was held in Cameron. Thomas E. Crump, Cameron, was elected president during the business session, while John T. Richards, Rockdale, was chosen vice-president and delegate, and Jack L. Walker, Cameron, was named secretary.

A resolution was passed which stated that the society believes it desirous for Milam County to participate in the regional blood bank of Waco and therefore will urge the local Red Cross to complete arrangements for this plan as soon as possible.

Polk-San Jacinto Counties Society

Herman A. Wall, Jr. of Corrigan recently was elected president of the Polk-San Jacinto Counties Medical Society. Roy A. Olive and John Corso, both of Livingston, are the new vice-president and secretary, respectively.

Tarrant County Society

October 21, 1952

(Reported by William P. Higgins, Jr., Secretary)

Symposium: Unilateral Shoulder and Arm Pain—E. Ross Kyger, Jr., Fort Worth, moderator; Rex Z. Howard, Henry C. McDonald, Jr., Frederick C. Rehfeldt, Herman C. Sehested, and Stephen W. Wilson, all of Fort Worth.

The regular monthly meeting of the Tarrant County Medical Society was held in Fort Worth on October 21, with sixty-two members present. A scientific program was given as outlined above. John F. Lindsay, Jr. and E. Renshaw Innis, both of Fort Worth, were elected to membership in the society, and the membership transfer of L. M. Altaras from the Hardeman-Cottle-Foard-Motley Counties Medical Society was approved. An amendment to the by-laws of the Tarrant County Society was proposed to raise the society's annual membership dues for use by the public relations committee and for other purposes. A letter was read from James D. Murphy, Fort Worth, chairman of the committee on scientific exhibits of the Texas Medical Association, regarding applications for scientific exhibit display space at the 1953 annual session of the Association.

AUXILIARY SECTION

COUNTY AUXILIARIES

Bexar County Auxiliary

The Woman's Auxiliary to the Bexar County Medical Society began its year of activity with a luncheon and meeting on October 10 at the Oak Hill Country Club in San Antonio. Mrs. S. Foster Moore, Jr., president, introduced Mrs. Robert F. Thompson, El Paso, President of the Woman's Auxiliary to the Texas Medical Association, who was honor guest and speaker. Other special guests introduced were Mesdames E. W. Coyle, President-Elect of the Auxiliary; John L. Pridgen, council woman for the Fifth District; Frank N. Haggard, member of the Special Advisory Committee and honorary life president of both the Woman's Auxiliary to the American Medical Association and the State Auxiliary; A. O. Severance, chairman of the Essay Committee; Frank Steed, member of the Memorial Fund Committee; Dan A. Russell, member of the Legislation Committee; and M. A. Ramsdell, member of the Nurse Recruitment Committee; and Drs. J. Manning Venable, president of the Bexar County Medical Society, and Wilber F. Robertson, counselor of the auxiliary, all of San Antonio.

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. Robert F. Thompson, El Paso; President-Elect, Mrs. E. W. Coyle, San Antonio; First Vice-President (Organization), Mrs. R. T. Travis, Jacksonville; Second Vice-President (Physical Examinations), Mrs. Troy A. Shafer, Harlingen; Third Vice-Presidents (Today's Health), Mrs. P. R. Jeter, Childress; Fourth Vice-President (Program), Mrs. John D. Gleckler, Denison; Recording Secretary, Mrs. Carlos R. Hamilton, Houston; Treasurer, Mrs. Oscar Marchman, Jr., Dallas; Corresponding Secretary, Mrs. Newton F. Walker, El Paso; Publicity Secretary, Mrs. A. H. Neighbors, Sr., Austin; Parliamentarian, Mrs. Joe D. Nichols, Atlanta.

Mrs. Thompson talked on the necessity of fulfilling the requirements and responsibilities of good citizenship in the immediate community as well as in America. Mrs. Pridgen gave the invocation. During the business meeting which followed, the names of the twenty-four new members of the auxiliary were announced; Mrs. Ramsdell introduced the new members present. Mrs. Phillip L. Day, San Antonio, chairman of the nurse recruitment committee, announced that the new loan fund for student nurses has been established by the society and is in readiness to be used. Members voted to sponsor the annual essay contest conducted by the Association of American Physicians and Surgeons and thereby bring the contest to the attention of Bexar County schools for the first time.

A Hawaiian cocktail and supper-dance "welcome" party for new members of the Bexar County Auxiliary and the Bexar County Medical Society took place in San Antonio, October 17. In the receiving line were Mrs. S. Foster Moore, Jr., president of the auxiliary, and Dr. Moore; Dr. J. Manning Venable, president of the county society, and Mrs. Venable; Mrs. John W. Worsham, social chairman, and Dr.

Worsham; and Mrs. Arthur B. Pyterek, new members chairman, and Dr. Pyterek. Official auxiliary hostesses were Mesdames Worsham, John B. Case, Graham B. Ladd, D. A. Todd, and Charles W. Tennison.—Mrs. L. Bonham Jones, Publicity Secretary.

Brown-Comanche-Mills-San Saba Counties Auxiliary

The Woman's Auxiliary to the Brown-Comanche-Mills-San Saba Counties Medical Society was organized at a meeting in Brownwood on October 16. Mrs. Scott H. Martin, San Angelo, council woman for the Fourth District, presented the plan of organization and presided over the business meeting. Officers of the auxiliary elected at this time include Mesdames Oscar N. Mayo, president; S. Braswell Locker, president-elect; Ernest F. Cadenhead, first vice-president; Ned A. Snyder, Jr., second vice-president; J. B. Stephens, secretary; Homer Allen, Jr., treasurer; and C. C. Bullard, parliamentarian. All are from Brownwood except Mrs. Stephens, who is from Bangs.

Harris County Auxiliary

Dan Smoot, coordinator of Facts Forum, was guest speaker at the October 27 meeting of the Harris County Auxiliary in Houston. Mr. Smoot's topic was "This Republic Is Yours."

A former member of the faculty of Southern Methodist University and a member of the Federal Bureau of Investigation, Mr. Smoot previously served as administrative assistant to J. Edgar Hoover. Mrs. Hardy A. Kemp, Houston, was chairman of the program.

Mrs. Robert F. Thompson, El Paso, President of the Woman's Auxiliary to the Texas Medical Association, was the honor guest at a luncheon and style show of the Harris County Auxiliary in Houston November 24. Models from the Cecil B. Lee Academie of Charm and Modeling participated in the style show. Mrs. Norborne Powell, Houston, served as chairman of the meeting.—Mrs. W. M. Wallis.

Hunt-Rockwall-Rains Counties Auxiliary

Members of the Hunt-Rockwall-Rains Counties Auxiliary entertained the counties medical society with a dinner on October 14 at the home of Dr. and Mrs. J. W. Ward of Greenville. Co-hostesses were Mesdames J. M. Hanchey, John S. Cooper, Henry W. Maier, George Trad, Samuel D. Whitten, Thomas C. Strickland, and E. T. Fry, all of Greenville.

Following dinner the two organizations met separately. Mrs. E. Truett Crim, president, presided at the auxiliary meeting.

Kerr-Kendall-Gillespie-Bandera Counties Auxiliary

The Kerr-Kendall-Gillespie-Bandera Counties Auxiliary began the year's activities with a tea on October 8 in Kerrville at "Steepside," the home of Dr. and Mrs. Sam E. Thompson.

Honored at this time was the President of the Woman's Auxiliary to the Texas Medical Association, Mrs. Robert F. Thompson of El Paso, Mesdames E. W. Coyle, President-Elect of the Auxiliary; John L. Pridgen, council woman for the Fifth District; A. O. Severance, chairman of the Essay Contest Committee of the State Auxiliary; Charles McGehee, member of the Auxiliary's Nominating Committee; and S. Foster Moore, Jr., president of the Bexar County Auxiliary, all of San Antonio, and Hugh A. Drane, Jr., Kerrville, president of the Kerr-Kendall-Gillespie-Bandera Counties Auxiliary, also were honored guests.

Kleberg-Kenedy Counties Auxiliary

Mrs. Clarke E. Ginther, Bishop, president of the Kleberg-Kenedy Counties Auxiliary, presided at the auxiliary's monthly meeting held on October 14 at the home of Mrs. S. Chester Dunn in Kingsville. At this time, tentative plans were made for a dinner honoring husbands of the members, and projects for the year were discussed. It was announced that Mrs. Lindell E. Ramey of Kingsville had been elected as secretary of the auxiliary and that a collection of books on government and citizenship had been received as a gift from the Woman's Auxiliary to the Texas Medical Association.

McLennan County Auxiliary

The McLennan County Auxiliary entertained with a brunch at the YWCA in Waco on October 22. Mesdames Milton Spark and Martin Even were chairmen for the brunch. Mrs. Maurice Barnes gave a talk on the United Nations, and Mrs. J. M. Garrett, president, reported on the meeting of the Executive Board of the Woman's Auxiliary held in Austin on September 18. Other reports were received from Mesdames M. C. Carlisle, J. L. Kee, and George Berry. It was announced that 1,503 subscriptions to *Today's Health* have been received since September.—Mrs. F. F. Kirby, Publicity Secretary.

Nacogdoches County Auxiliary

Mrs. Eugene S. Rogers entertained members of the Nacogdoches County Auxiliary at a luncheon on November 5 in Nacogdoches. Final plans were made for the sixth annual silver tea held November 13 at the home of Mrs. Stephen Tucker of Nacogdoches.—Mrs. James G. Taylor, Jr., Publicity Secretary.

Nueces County Auxiliary

Thirteen new members of the Nueces County Auxiliary were welcomed at the October meeting of the auxiliary in Corpus Christi. Special guests were wives of physicians at the Naval Hospital and Naval Air Station. The new members were invited to attend the luncheon and business meeting held November 21 with Mrs. G. W. Edgerton as hostess chairman.

New members include Mesdames Herman W. Gaddis, T. F. Fitzgerald, William Aldis, D. C. Bernwanger, Rex Thomas, Harold T. Pruessner, Robert Wilkens, Joseph Oshman, Robert W. Johnson, George Schuster, T. P. O'Brien, Maurice Nast, and Lloyd D. Bounds.—Mrs. C. D. Stewart, Press Reporter.

Travis County Auxiliary

The Woman's Auxiliary to the Travis County Medical Society met in Austin on October 21 to honor new members and members of other county auxiliaries in the Seventh District. Approximately 115 persons were present. Mrs. Allen H. Neighbors, Jr., Austin, president, conducted the business session and program. A play written by Mrs. Neighbors and called "Rehearsal for Duty" was presented. Its theme stressed the importance of auxiliary members' participation in the health education, philanthropic, community service, nurse recruitment, legislative, hospital service, and essay contest committees.

Hostesses were Mesdames Richard O. Swearingen and Robert B. Morrison, co-chairmen; and Neighbors, William W. Kelton, Jr., Thomas J. Archer, Sidney W. Bohls, W. Burford Hahn, George W. Tipton, James W. Eckhardt, J. Edward Johnson, Rabun T. Wilson, Charles B. Dildy, Gabriel F. Thornhill, Henry L. Hilgartner, Terrence Watt, Dalton Richardson, Ben M. Primer, Lee E. Edens, Zachary T. Scott, and Jay T. Shurley, all of Austin.

Mrs. Robert F. Thompson, El Paso, president of the Woman's Auxiliary to the Texas Medical Association, was honoree at a luncheon style show held in Austin on Novem-

ber 18 for the Travis County Auxiliary. Mesdames Robert V. Murray, Carl E. Carter, J. W. E. H. Beck, Rabun T. Wilson, James M. Coleman, James T. Robinson, R. Allwyn Cooper, and Allen H. Neighbors, Sr., all of Austin, and past presidents of the county auxiliary were other special guests.

Mrs. Thompson spoke briefly on "Americanism." Mrs. Horton Wayne Smith of Austin was moderator for the style show, while a group of auxiliary members were models. They included Mesdames Henry L. Hilgartner, Charles M. Darnall, Emerson K. Blewett, Terrence Watt, Robert B. Morrison, Horace E. Cromer, James W. Eckhardt, Thomas J. McElhenney, and Wylie F. Creel.

Chairmen of hostesses were Mrs. Cromer and Mrs. Frank M. Covert, III. On the hostess committee were Mesdames Raleigh R. Ross, David O. Johnson, Blewett, James E. Kreisle, John F. Thomas, Albert A. Tisdale, George E. Clark, Jr., Gus G. Zedler, David Wade, Claude A. Martin, Luther P. Walter, W. C. Gauntt, Sam A. Woolsey, and M. Allen Forbes, Jr. All of the participants are from Austin.—Mrs. George W. Tipton, Publicity Secretary.

DEATHS

J. D. MABRY

Dr. James Delma Mabry, Houston, Texas, associate professor of clinical surgery at Baylor University College of Medicine, died in a Houston hospital on September 10, 1952, following a heart attack.

Dr. Mabry was born at Abbott on November 3, 1901, the son of Jesse H. and Cora (Johnson) Mabry. He attended Abilene Christian College, Abilene, and Baylor University, Waco, and received his bachelor of arts degree from the University of Colorado, Boulder. Dr. Mabry obtained his medical degree in 1928 from the University of Texas School of Medicine, Galveston.

After serving his internship and residency at Hermann Hospital, Houston, he entered private practice in that city in 1931. Since 1937 he had been on the surgical staff of Hermann Hospital and was senior member of the active staff at the time of his death. Dr. Mabry also taught at Baylor University College of Medicine, Houston. During World War II he served for forty-one months in the Navy, holding the rank of commander. He was credited with setting up the first naval hospital on Guadalcanal.

DR. JAMES D. MABRY

Dr. Mabry had been a member for many years of the American Medical Association and the Texas Medical Association through the Harris County Medical Society. He was a member of the military affairs committee and on the board of censors of his county society. A fellow of the American College of Surgeons, Dr. Mabry also held membership in the Postgraduate Assembly of South Texas and was vice-president of the Harris County Chapter of the American Academy of General Practice. In addition, he was a member of the Arabia Temple Shrine, the Houston Club, Theta Kappa Psi medical fraternity, the Houston Chamber of Commerce, the Central Church of Christ, and was on the executive committee of Doctors for Freedom, a civic group which he helped organize.

Dr. Mabry is survived by his wife, the former Miss Gladys Hooks, whom he married in San Diego, Calif., on May 14, 1942; his father and stepmother, Mr. and Mrs. J. H. Mabry, Penelope; four brothers, Homer Mabry and A. W. Mabry, Houston; Leon Mabry, Dallas; and Richard W. Mabry, Penelope; and three sisters, Mrs. J. Howard, Waco; Mrs. Warren Berryhill, Hillsboro; and Mrs. Myron Matteson, Magnolia, Ark.

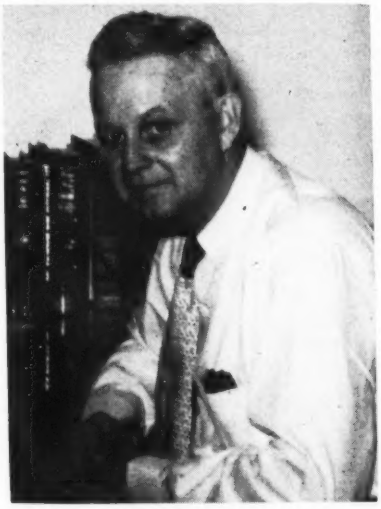
P. D. PRIEST

Dr. Perry Davis Priest, Texarkana, Texas, died September 22, 1952 in a Texarkana hospital from cerebrovascular thrombosis, after having been ill for several months.

Dr. Priest was the son of Mr. and Mrs. Augustus Priest and was born at Inverness, Fla., on March 20, 1902. He received most of his preliminary schooling in North Carolina, where he attended high school at Black Mountain; Mars Hill College Preparatory School, Mars Hill; the University of North Carolina, Chapel Hill; and Davidson College, Davidson. Upon graduation with a bachelor of science degree from the latter, Dr. Priest entered Vanderbilt University School of Medicine, Nashville, receiving his medical degree in 1931. He was awarded the Beauchamp Prize in neuropsychiatry following his graduation. After graduation Dr. Priest remained at Vanderbilt four years for postgraduate training which included two years in internal medicine and two years in pediatrics. In addition Dr. Priest was associated with the out-patient department of Vanderbilt Hospital. In 1935 he established his medical practice at Texarkana and continued to practice in that city until the onset of his illness in June. Dr. Priest was engaged in the general practice of medicine and was a member of the staffs of Texarkana and St. Michael's Hospitals, Texarkana. When the Vanderbilt Medical Unit was activated as 300th General Hospital during World War II, Dr. Priest was chief of medical service for one year before receiving an honorable medical discharge from the Army Medical Corps with the rank of lieutenant colonel.

Dr. Priest was a member of the American Medical Association and the Texas Medical Association through the Bowie

County Medical Society, of which he was president in 1947. He was also a member of Alpha Omicron Alpha honorary medical scholastic fraternity, Phi Beta Kappa honorary scholastic fraternity, Alpha Kappa Kappa medical fraternity, Delta Tau Delta social fraternity, and the Baptist Church.



DR. PERRY PRIEST

Dr. Priest is survived by his wife, the former Miss Mary Adele Wilson, whom he married in Texarkana in 1938; a son, Stuart Wilson Priest; and a daughter, Penelope Priest, all of Texarkana; his mother, Mrs. Cora Lee, Anniston, Ala.; and two sisters, Mrs. A. M. Chilton, Anniston, Ala., and Mrs. G. A. Edwards, Van Wert, Ohio.

J. L. HAWLEY

Dr. James Leeper Hawley, Tyler, Texas, clinical director of the East Texas Tuberculosis Hospital, died October 12, 1952 at his home.

Dr. Hawley was born at Sherman on April 4, 1910. His parents were H. B. and Beatrice Hawley. Dr. Hawley was a graduate of North Dallas High School, Dallas; Texas Agricultural and Mechanical College, College Station; and Baylor University College of Medicine, then located in Dallas. He received his medical degree in 1935 and served both his internship and residency at Baylor Hospital, Dallas. Dr. Hawley began private practice in Dallas in 1938 with the late Dr. J. Forrest Buchanan. Later, he became associated with the Tuberculosis Control Center, Dallas. From 1948 until 1950 Dr. Hawley was on the staff of the Veterans Administration Hospital at Legion. He moved to Tyler in 1950 to join the staff of the East Texas Tuberculosis Hospital. Internal medicine was his specialty.

Dr. Hawley formerly was a member of the American Medical Association and the Texas Medical Association through the Dallas County Medical Society. He was also a member of Phi Chi medical fraternity, Alpha Omega Alpha honorary medical fraternity, and the Episcopal Church.

His wife, the former Miss Pearl Sutherland whom Dr. Hawley married June 8, 1937, survives him, in addition to two sons, James Hawley, Jr., and Joe Hawley, all of Dallas; three brothers, Hugh Hawley, Los Angeles; Orrin Hawley, Dallas; and Joe Hawley, Bandera; and a sister, Mrs. M. M. Paule, Dallas.

R. L. DAVIS

Dr. Robert Lee Davis, McKinney, Texas, a practicing physician for sixty years, died September 30, 1952 in a McKinney hospital, following a short illness.

Dr. Davis was born on November 6, 1865 in Farmersville, Texas, to John A. and Sarah (Roland) Davis. He attended Farmersville public schools before enrolling in what was then the Memphis Hospital Medical College, Memphis, Tenn., where he was graduated in 1892 and served his internship. He began his medical practice in the vicinity of Princeton, Texas. In 1917 Dr. Davis moved to McKinney, where he practiced until the time of his death.

DR. ROBERT LEE DAVIS

Dr. Davis was formerly a member for many years of the American Medical Association and the Texas Medical Association through the Collin County Medical Society. He was president of his county medical society in 1948 and served as city and county health officer for several years. Dr. Davis was a member of the Baptist Church.

On March 25, 1885 in Farmersville, Dr. Davis married the former Miss Lenora B. Chapman. His wife survives him, as do four daughters, Mrs. W. Porter Cave, Mrs. S. Stanley Knapp, and Mrs. M. M. Winzer, all of Dallas, and Mrs. Zollie Taylor, McKinney; a brother, Rev. M. I. Davis, Nogales, Ariz.; a sister, Mrs. Nan Murchison, Shamrock, Texas; ten grandchildren; and eight great-grandchildren.

L. H. COCKERHAM

Dr. Louis Hampton Cockerham, Sinton, Texas, died July 13, 1952, in a Sinton hospital.

Dr. Cockerham was born in Coushatta, La., on August 25, 1888, the son of Moses Allan and Maggie (Sheen) Cockerham. He received his medical degree in 1914 from the old St. Louis College of Physicians and Surgeons in St. Louis, and interned at Parkland Hospital, Dallas.

Dr. Cockerham practiced in Laredo, Iola, and Palestine, before moving to Sinton in 1927. He maintained an active practice in Sinton until 1951 when ill health forced him to retire. In 1941 he and Dr. C. L. Curlee built the Sinton Hospital. During World War I, Dr. Cockerham served as a first lieutenant in the Army Medical Corps. He was stationed

overseas and was wounded twice, receiving the French Croix de Guerre for his services.

A member of the American Medical Association and the Texas Medical Association through Webb-Zapata-Jim Hogg, Grimes, and San Patricio-Aransas-Refugio Counties Medical Societies, Dr. Cockerham had served as president of the latter society in 1934. He was elected to honorary membership in the Texas Medical Association in 1952.

Dr. Cockerham owned extensive farm and ranch interests, and upon his retirement from active practice, spent his time looking after these interests. He was a member of the Masonic Lodge and the Methodist Church.

Dr. Cockerham married the former Miss Lola Neill on May 26, 1923, in San Antonio. She survives him as do a son, Louis Cockerham, Sinton, and a daughter, Mrs. Dave Odem, Sinton; one brother, Clyde Cockerham, Baton Rouge, La.; a sister, Mrs. Charles Mueller, Commerce; and four grandchildren.

M. A. H. EDGERTON

Dr. Mary Ann (Headley) Edgerton, Rio Grande City, Texas, died in a San Antonio hospital August 29, 1952, of cancer.

Dr. Edgerton was born at Miramar Ranch in Hidalgo County, Texas, on October 28, 1888, the daughter of Dr. A. M. and Dona Marie (del Pilar Trevino) Headley. Her father was a native of England who settled in the Rio Grande Valley soon after the Civil War, in which he served as a surgeon with the Confederate Army. Dr. Edgerton received her early education in Rio Grande City, attending the public schools and Incarnate Word Convent, in addition

DR. MARY EDGERTON

to being privately tutored. She studied at the University of Texas, Austin, as well as the University of Texas School of Medicine, Galveston, prior to receiving her medical degree in 1910 from the Woman's Medical College of Pennsylvania, Philadelphia. Afterwards she began her postgraduate work at the Wills Hospital, Philadelphia, but she soon returned to her former home in order to assist her father with his practice. In 1911 during a smallpox epidemic, Dr. Edgerton was appointed county health officer. She is credited with having been able to control the epidemic within ninety days. She also served Starr County as its health officer at other times during her medical career. Following the death of her father, Dr. Edgerton and her husband, Dr. George Edgerton, assumed Dr. Headley's practice.

Dr. Mary, as she was known to her patients, was in active practice for twenty-five years. She specialized in gynecology. Dr. Edgerton was a member of the American Medical Association and the Texas Medical Association through the Hidalgo-Starr Counties Medical Society.

In 1912 she was married to Dr. George Edgerton of Sherman. Surviving her are four sons, George H. Edgerton, Austin; Charles H. Edgerton and Robbie H. Edgerton, Corpus Christi; and Joe H. Edgerton, San Antonio; a daughter, Mrs. Estella E. Raybourn, Harlingen; and six grandchildren.

W. D. McDONALD

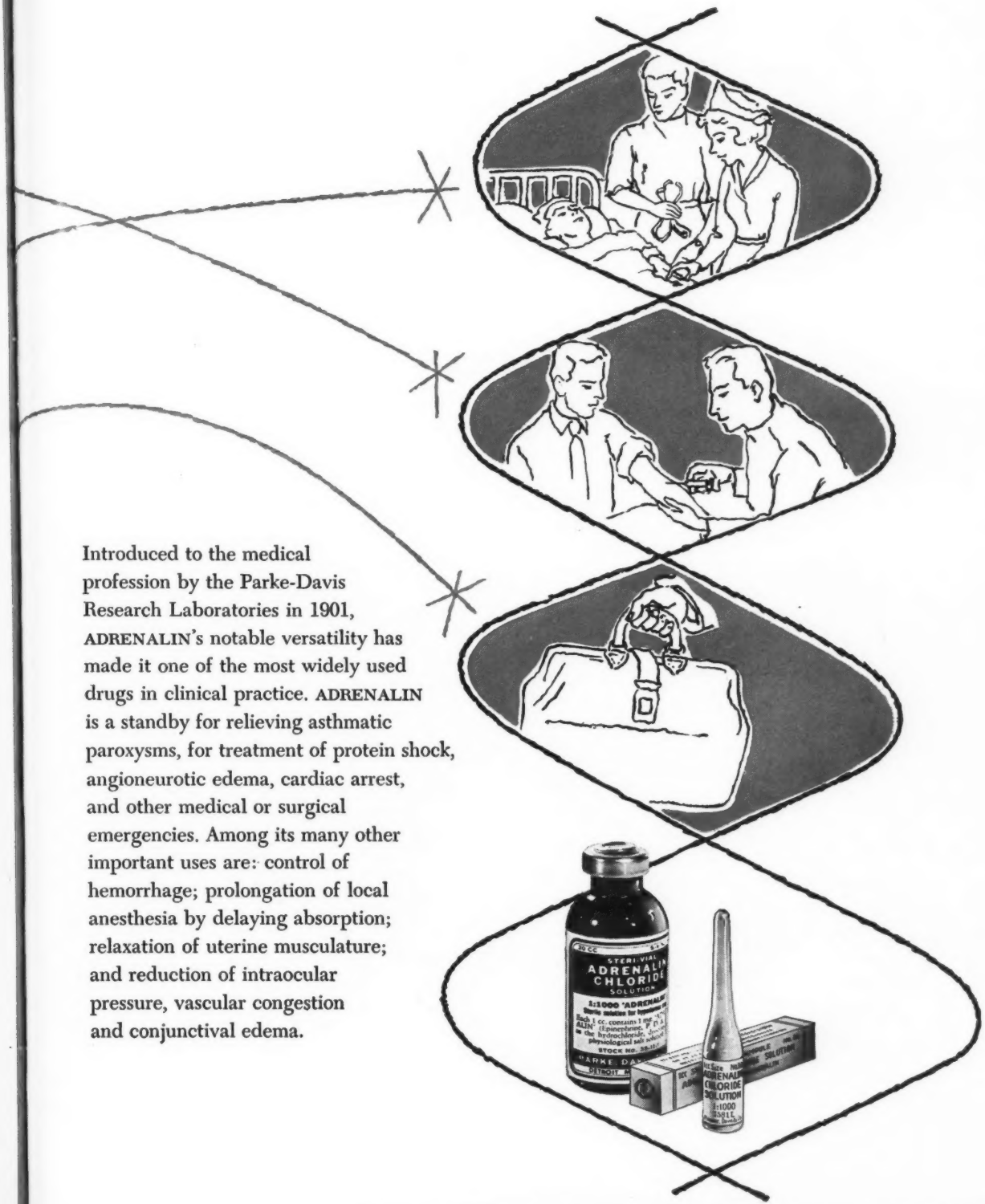
Dr. William Drury McDonald, Dallas, Texas, died August 21, 1952 at Lake City, Colo., from acute myocardial infarction.

Dr. McDonald, the son of W. F. and Mary J. McDonald, was born December 25, 1904 at Red Level, Ala. From 1923 through 1926 he was a student at the University of Florida in Gainesville. He also attended the University of Alabama at Tuskaloosa before enrolling at the University of Arkansas School of Medicine, Little Rock. He was graduated from the latter school in 1933 and then interned at St. Paul's Hospital in Dallas for one year. After completing his internship, Dr. McDonald established his medical practice in Dallas and continued to practice in that city until his death; he specialized in obstetrics and gynecology.

DR. W. D. MCDONALD

Dr. McDonald was a member of the American Medical Association and the Texas Medical Association through the Dallas County Medical Society, the Southwestern Medical Association, the American Academy of Obstetrics and Gynecology, the Dallas-Fort Worth Obstetrics and Gynecology Society, and Theta Kappa Psi medical fraternity.

Dr. McDonald married the former Miss Viola Adelle Young, also a doctor of medicine, on March 27, 1931 at Fordyce, Ark. She survives him, in addition to a son, Robert Drury McDonald; a daughter, Sarah Adelle McDonald; and his mother, Mrs. Mary Kennedy, all of Dallas.



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J. A. Coleman, M. D.
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Claudia Potter, M. D. (Retired)
Surgical Pathology:
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E. E. Seedorf, M. D.
Arno W. Sommer, M. D.
Clinical Pathology:
W. N. Powell, M. D.
Chiropody:
L. M. Hoppock, D. S. C.
Allergy:
A. Ford Wolf, M. D.
Cardiology:
O. B. Gober, M. D.
Diabetes:
R. G. Greenlee, M. D.
Gastroenterology:
A. C. Broders, Jr.
Medical Diseases of Chest:
W. O. Arnold, M. D.
Pediatrics:
B. H. Williams, M. D.
Obstetrics:
T. F. Bunkley, M. D.
J. T. Campbell, Jr., M. D.
Dermatology & Syphilology:
R. A. Stevenson, Jr., M. D.
General Practice:
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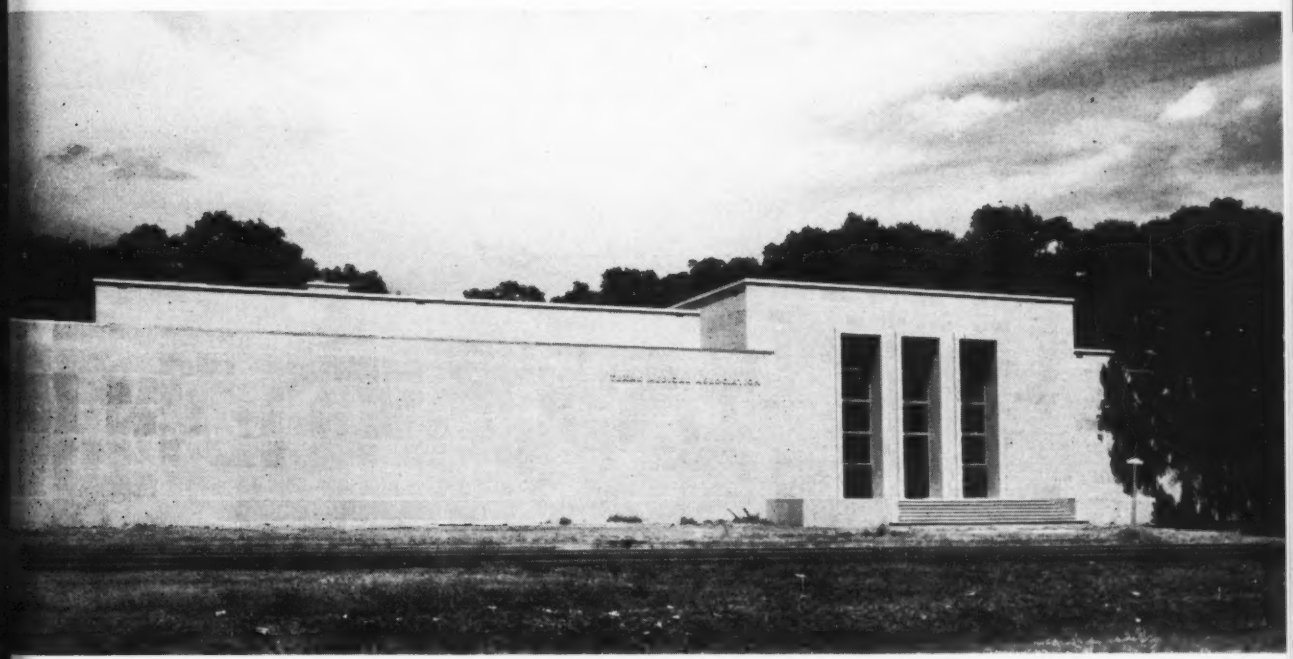
TEXAS STATE JOURNAL OF MEDICINE

Special Section

Austin, Texas, September, 1952



TEXAS MEDICAL ASSOCIATION

Memorial Library

DEDICATION CEREMONIES

September 19-21, 1952

Austin, Texas

wherever the art of medicine is loved,
there also is the love of humanity.

Hippocrates: Aphorisms, circa 400 B. C.

AYERST, MCKENNA & HARRISON offers hearty congratulations to THE TEXAS MEDICAL ASSOCIATION on the opening of their new headquarters. It has been our privilege, over the years, to observe the swift and steady growth of the Texas Medical Association, and we are proud to be given this opportunity to extend our sincere wishes for its continuing progress.

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SAN ANTONIO, TEXAS

DEDICATED TO BETTER HEALTH

The new memorial library and headquarters building of the Texas Medical Association belongs not only to the physicians of Texas but to Texas citizens everywhere. The dedication ceremonies from Friday, September 19, through Sunday, September 21, underscore that fact.

Formal services will be held Friday, one program at 5 p. m. paying special tribute to past presidents of the Texas Medical Association and a second at 8 p. m. dedicating the edifice to better health for all Texas. The Friday programs are primarily for members of the medical profession, their families, and distinguished guests from virtually every profession and from all parts of the nation. A day-long open house Sunday is set aside for the public.

Dr. Louis H. Bauer, Hempstead, N. Y., President of the American Medical Association and Secretary-General of the World Medical Association, will deliver the principal dedicatory address Friday evening. He will be introduced by the Governor of Texas, Allan Shivers. United States Senator Lyndon B. Johnson will present the main talk at the afternoon ceremonies.

A. Frank Smith, Houston, bishop of the Methodist Church, will deliver the invocation for the Friday afternoon services. Dr. T. C. Terrell, Fort Worth, President of the Association, will preside and introduce Dr. George Turner, El Paso, President-Elect of the Association, and Mrs. Robert F. Thompson, El Paso, President of the Woman's Auxiliary. Dr. Terrell also will present silver medallions to each past president on behalf of the Association. Senator Johnson's address will conclude the program. He will be introduced by Congressman Homer Thornberry of Austin.

Dr. Merton M. Minter, San Antonio, chairman of the Board of Trustees, will preside Friday night with Dr. W. R. White, Waco, president of Baylor University, delivering the invocation. Dr. Minter also will acknowledge the service which Dr. Sam N. Key, Austin, has performed as chairman of the Building Committee. Formal naming of the auditorium-lounge in honor of Dr. and Mrs. Sam E. Thompson of Kerrville will precede the introduction of Governor Shivers, who in turn will present Dr. Bauer.

Saturday's activities will be concerned primarily with the convening of the Association's Executive Council and many of its committees. However, these meetings will take place in downtown Austin to keep the building clear for inspection by doctors and their families who are unable to view it Friday. A meeting of the Executive Board of the Woman's Auxiliary, to be held in Austin on Thursday, September 18, likewise will be away from the building.

Sunday morning at 10 o'clock the doors will swing wide to all Texans, and open house will continue until 6 o'clock in the afternoon. Ten and fifteen minute motion pictures ranging from "Wonder Engine of the Body" to "Your Doctor for a Friend" and "New Frontiers of Medicine" will be shown continually in the auditorium.

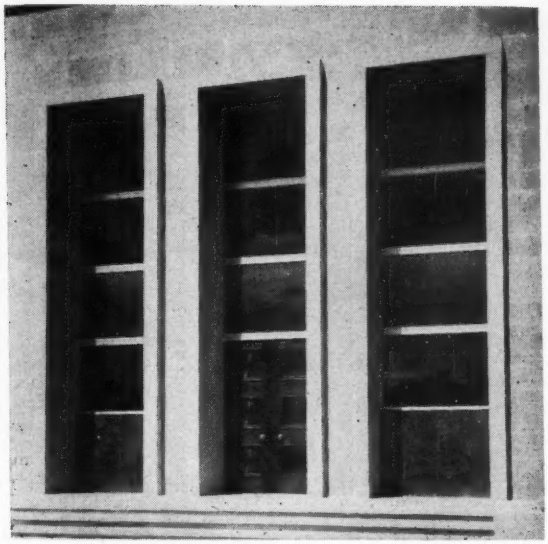
A thirty minute broadcast summarizing the entire three-day program will be carried as a public service over the Texas State Network on Sunday at 7 p. m.

Almost one hundred years ago, in 1853, the physicians of Texas met to establish a medical organization, believing that by cooperation and exchange of ideas they could improve themselves and make a more meaningful contribution to the health of citizens of the state. The new library and headquarters building reflects the growth of this organization and the continuing interest of its members in providing ever increasing and ever better medical service to the people of Texas.

LOUIS H. BAUER, M. D., F.A.C.P.

LYNDON B. JOHNSON, UNITED STATES SENATOR

THE LATCH STRING IS OUT



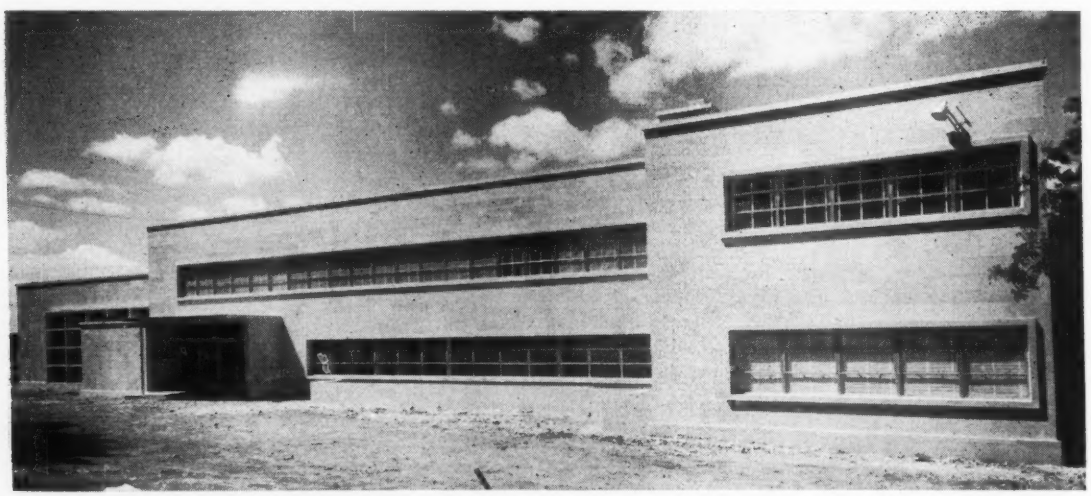
Main entrance to the Memorial Library of the Texas Medical Association in Austin.

The Texas Medical Association building is on a corner lot where Lamar Boulevard, one of the chief north-south arteries of Austin, is met by Nineteenth Street, a convenient east-west thoroughfare. Facing approximately west on Lamar, the limestone edifice with granite trim snuggles against a tree-lined bluff in the rear and overlooks a city park in front. The almost windowless west facade emphasizes the modern architecture which has been modified to lend dignity to the two-story with basement structure. Twin rows of windows across the back permit both floors to have full benefit of the northeastern light.

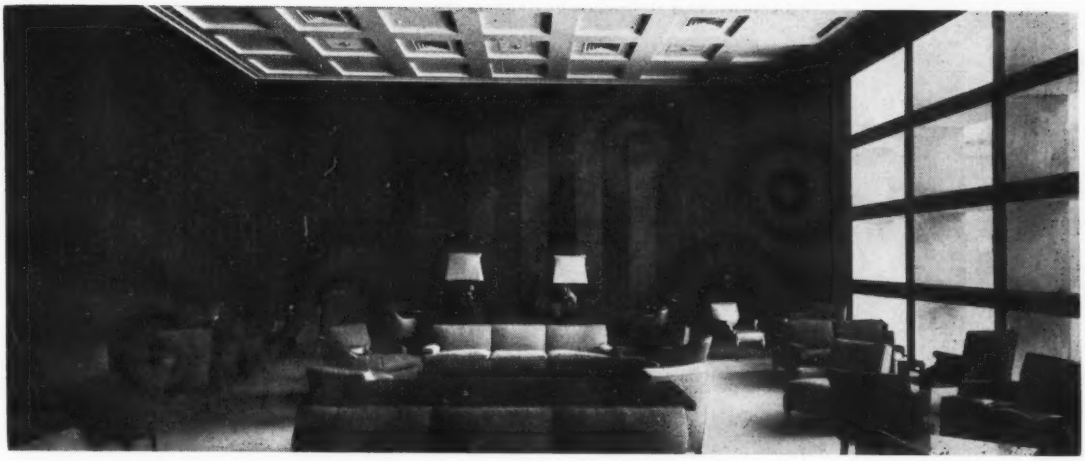
Formal double doors at the main entrance, an automobile entrance at the rear, and a service entrance offer access to the first floor, which is occupied entirely by the library and an informal lounge-auditorium to seat 300. Two staircases and a service elevator rise to the second floor, where the executive, business, *Journal,* medical services, public relations, State Advisory Committee, and Woman's Auxiliary offices are located. A large basement area is available for storage as well as for housing a photographic dark room and the furnace, incinerator, and air conditioning equipment.

Plaster walls in soft colors with harmonizing asphalt tile floors, sound-absorbing ceilings, and fluorescent lighting prevail. Wood paneling and leather, together with decorative draw drapes enhance the beauty of the main reading room of the library and of the auditorium-lounge. A kitchen adjacent to the auditorium will permit refreshments for groups meeting there, and a small kitchen unit in the staff lounge will serve their needs.

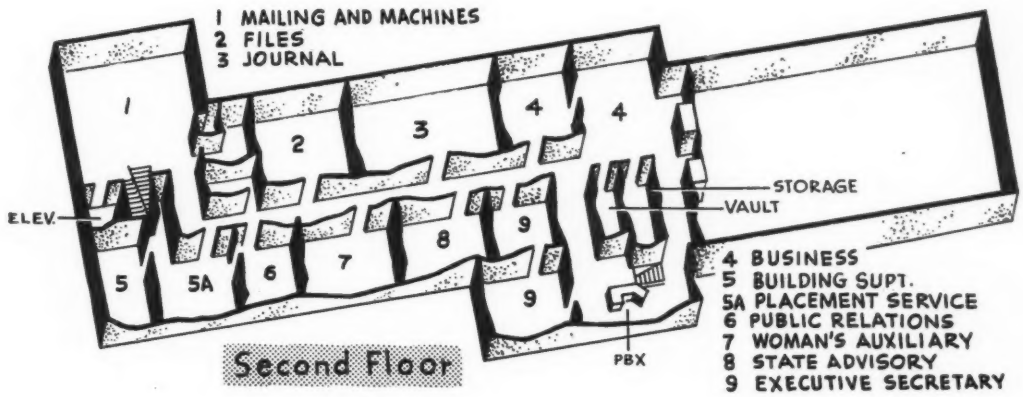
Parking facilities on the Association property will take care of 20 automobiles, and an additional 40 cars can be parked within a block of the building.

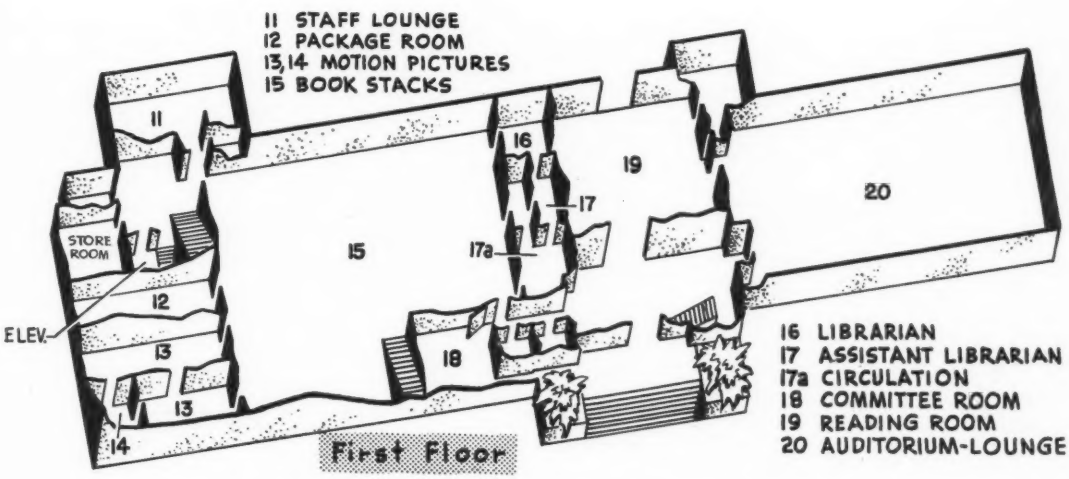


Back view of the Association building showing the windows of the auditorium-lounge at the extreme left, the rear entrance into the main reading room, and rows of windows for library and offices.

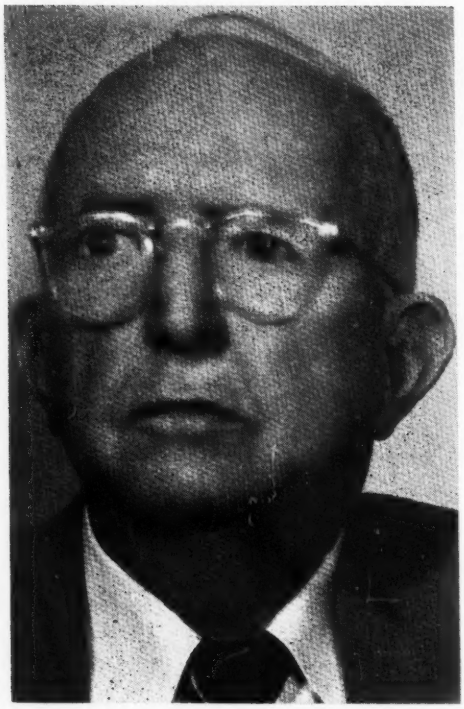


View of the auditorium-lounge at the south end of the first floor.





Diagrams picturing the location of principal rooms on the first (library) and second (office) floors.



SAMUEL EVANS THOMPSON, M. D., F.A.C.P.

ANNIE LEE (PINSON) THOMPSON

DR. AND MRS. SAM E. THOMPSON ROOM

A bequest of $50,000 to the Texas Medical Association, provided for in an irrevocable trust, has been given by Dr. and Mrs. Sam E. Thompson of Kerrville for use in building and operating the library of the Association. In appreciation of this gift, the Board of Trustees unanimously voted to name the auditorium-lounge of the new central office and library building in honor of Dr. and Mrs. Thompson.

"Dr. Sam," now in his eighty-first year, is a man who earned the respect of his colleagues because of his ability as a physician and his loyalty to the traditions of medical practice which have contributed so much to the good health of the American people. Born in Clairborne Parish, La., Dr. Thompson grew up in southern Arkansas, was graduated in medicine from the University of Louisville, and began practice in El Dorado, Ark. Stricken with tuberculosis, he moved to San Angelo, and upon his recovery turned to the treatment of tuberculosis as his specialty. First as medical director of the State Tuberculosis Sanatorium at Carlsbad and then as director of a private sanatorium at Kerrville, Dr. Thompson became grounded in the therapy of tuberculous patients and decided to open his own sanatorium. From 1918 until he sold the property to the state in 1936, Thompson's Sanatorium was one of the chief "industries" of Kerrville.

Although he found time to participate in civic organizations (he was district governor of Rotary, for example), Dr. Thompson never neglected his professional societies. Throughout his career he has been affiliated with the county, district, state, regional, and national medical societies and associations, holding positions of trust in almost all of them. After serving as president of the Texas Medical Association in 1934-1935, he was elected to the Board of Trustees in 1939, resigning in 1946 after ten years as chairman. He was named to emeritus membership in the Association in 1948. He was a delegate to the American Medical Association for twelve years.

Mrs. Thompson, a native of El Dorado, Ark., was born Annie Lee Pinson. Married shortly after completion of her high school studies, she bore two sons by her first husband. She and Dr. Thompson were married in 1914 and have no children. A charter member of the Kerr-Kendall-Gillespie-Bandera Counties Auxiliary, Mrs. Thompson has offered the same kind of enthusiastic and able leadership in the woman's organizations affiliated with the medical profession as Dr. Thompson has to the physicians' associations. In addition to serving her county auxiliary as president for several terms, Mrs. Thompson was state president in 1944-1945.

Dr. and Mrs. Thompson are known for their informal hospitality. The friendliness which pervades "Steepside," the Thompson home on a hill overlooking the Guadalupe River, extends outward in many ways, not the least of which is in the form of cash donations to projects of many kinds in Kerrville and elsewhere. Each contribution carries with it the conviction of the donors that the project is worthy of support, and they give their interest and time along with their money.

Every member of the Texas Medical Association and its Woman's Auxiliary joins with the Board of Trustees in appreciation of the magnificent gift which the Thompsons have provided. Through the years, the medical profession of Texas will have cause to remember this doctor and his wife because they believed enough in the Association and the services of its central office and library to want to assure their continuation.

Growth of the Association Offices

A permanent headquarters for the Texas Medical Association probably was not considered seriously by the thirty-five physicians who attended the first annual session in 1853 or by any of the doctors who participated in the reactivation and organization of the Association in 1869. However, during the years from 1869 until 1903, officers and members of the Association mentioned before the House of Delegates at the annual sessions the advisability of a permanent home and library.

As early as 1884 discussion of the establishment and housing of a library and museum was recorded in the transactions. At this time a committee appointed to study the subject of a museum and library recommended that Dr. Ashbel Smith, president of the Board of Regents of the University of Texas, set apart a room or rooms for consideration as a museum and library.

In 1887 the secretary reported that the library had 537 volumes and he was directed to secure a room for their storage in the new Capitol Building. He reported failure the next year. In 1904 the president, Dr. Frank Paschal, urged the House of Delegates to consider again a permanent place of meeting and the establishment of a pathologic museum and state medical library.

In these early years of the Association, while Texas physicians continued to talk about a library and museum, the business activities of the Association were carried on by the officers in their private offices and hospitals by their own secretarial staffs. From 1903 until many years later, the only headquarters as such for Association business was the office of the secretary, Dr. Ira Chase, who in addition to serving as Association secretary, became the editor-in-chief of the *Journal* at its institution in July of 1905, with the fifteen district councilors serving as associate editors. At that time Dr. Chase's office was in the Fort Worth National Bank Building, where he devoted part time to the jobs of secretary and editor-in-chief and the rest of the time to his practice of medicine. He served as *Journal* editor and secretary until 1910. A fire in the Association office forced Dr. Chase to move to new quarters in the basement of the Continental Bank Building in Fort Worth, taking with him all the Association files and materials and setting up what was probably the second "home" for Association activities.

In a *Journal* editorial in June, 1906, Dr. Chase urged securing a permanent home for the Association to be used as a meeting place, medical library, and museum. By 1907 the Association had three employees, the *Journal* showed a profit, and membership had reached 2,910. In 1908 Dr. Chase reported in the *Journal* that the Association's office space had gradually increased to 45 by 15 feet which held desks, files, typewriters, cabinets, and storage of journals and books.

"The collection now consists of 234 Texas transactions; 394 volumes of Transactions of other states; 246 miscellaneous books; 7 late medical books reviewed by the *Journal;* 30 medical books on hand for review; 16 bound volumes of the *Texas State Journal of Medicine;* 2,400 unbound back numbers of the *State Journal;* 18 bound volumes of late American medical journals," the *Journal* stated.

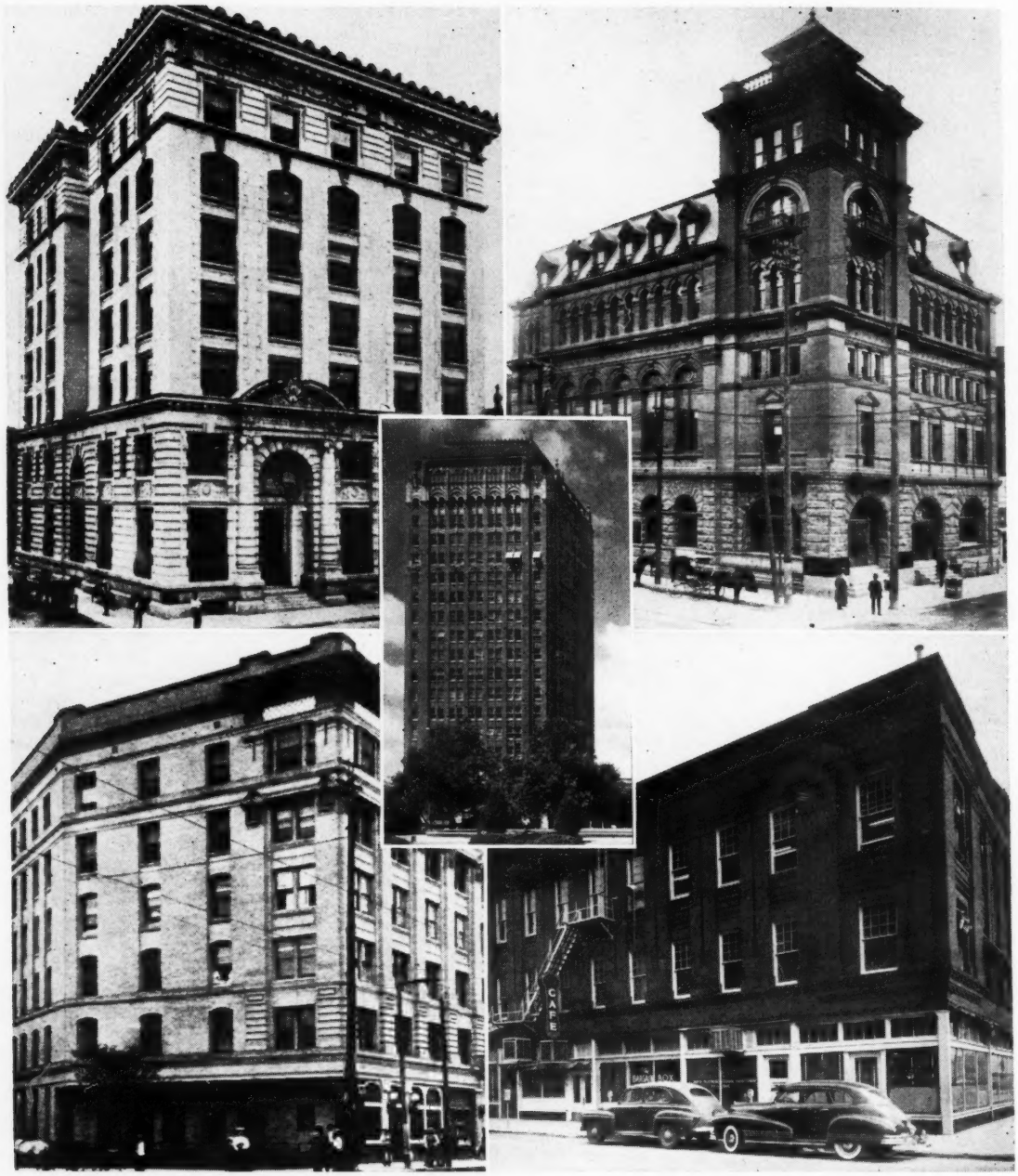
In this report Dr. Chase again suggested that the Trustees plan for the future, pointing out that the expected increase in books and membership would make advisable securing a fireproof building and its equipment.

The year 1910 marked an increase in membership to 2,992 and the beginning of the medical library, an important service to be housed in the central headquarters. The first volumes other than the bound yearly transactions were gifts from Fort Worth physicians and publishers. The exact number of books and periodicals at that time is not recorded, and they were not available to any member unless he had time to go to the headquarters office and find the material he desired. In 1912, the year in which the new quarters for the offices of the *Journal* and the secretary–editor-in-chief were moved to the Western National Bank Building, Dr. Holman Taylor, who succeeded Dr. Chase in 1910 and served for thirty-seven years, announced that the new office housed the library, back journals, and office supplies, but regretted that the staff was not large enough to allow them to look up references for physicians. It was probably after this move that the library was consolidated with the library of old Fort Worth Medical College and all books and journals were given to the medical college.

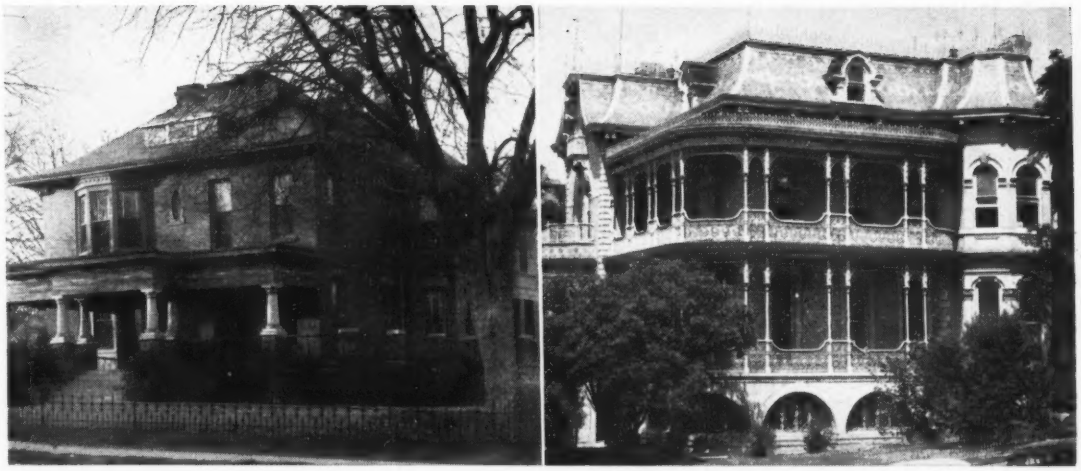
Dr. John T. Moore, president of the Association in 1911, reopened the issue of seeking a permanent home for the Association. During the time between 1910 and 1920, many advances in medicine were noted and the Association's activities expanded. A plan of medical defense was adopted in 1914 and the *Journal* made its first change in format when the twenty-two state medical journals formed a cooperative advertising bureau and a uniform page size became desirable. The yearly election of a president-elect was established and scientific exhibits were displayed at an annual session for the first time in 1915. Cancer, typhus fever, and poliomyelitis were topics on the scientific program of the day and the program of medical preparedness in Texas became far-reaching with the country's entry into World War I. Twenty per cent of the Association members went to war, including the secretary and editor-in-chief, Dr. Taylor. In May, 1917 the first county auxiliary in the United States was organized in Dallas. The following year the *Journal* got an advertising manager.

In 1919 the Association renewed attempts to establish its own library. For the next nine years there was a rapid accumulation of books and journals, but without a librarian these items were not of great value to Association members. Headquarters of the Association were moved in 1922 with the Tarrant County Medical Society to the second floor of the Newby Building at Throckmorton and Eleventh Streets over the old Gas Company offices.

Dr. R. B. Anderson came to the Association as assistant secretary in 1927 succeeding Dr. D. R. Venable, who had served as assistant to the secretary-editor since 1923. Through Dr. Anderson's work and guidance, the library was reorganized and the package library service begun. It was not until 1931 that a full time assistant librarian was employed to be trained under Dr. Anderson and the library's contents were completely indexed and made available to



In the Fort Worth National Bank Building (upper left), the first building to house offices of the Texas Medical Association, activities were carried on in the quarters of the secretary–editor-in-chief until 1910, when offices were set up in the basement of the Continental Bank Building (upper right). The third move took place in 1912, when the Association office was housed in the Western National Bank Building, later known as the Texas State Bank Building (lower left). For five years, from 1922 to 1927, the central office was located on the second floor of the Newby Building at 207½ West Eleventh, over the old Gas Company offices. In the photograph of the Newby Building (lower right), which was taken recently, the windows above the fire escape toward the east (left) are those of the former Association office. Other space on the second floor was used by the Tarrant County Medical Society. "Home" from 1927 until 1935 was on the second floor of the Medical Arts Building in Fort Worth (inset).



The first home of the central office which was owned by the Association was secured in 1935 in Fort Worth at 1404 West El Paso Street (left), the former residence of a prominent Fort Worth family. For the first time, the central office staff and activities made use of a complete building. The Victorian residence at 700 Guadalupe Street in Austin (right) housed the Association's offices from 1948 until this year, when they were moved to the new structure on Lamar Boulevard.

members of the Association. The total number of items consulted and loaned during 1931 was 1,836. That year the accumulation of reprints began and by 1933, the reprint volume reached 31,200. The need for adequate space to house these reprints, more than 4,000 bound volumes, and 7,800 unbound journals and to have more space for the yearly accretion of 1,746 journals and 100 books became evident. Membership in the Association in 1933 was 3,455.

In 1927 the central office was moved again, this time to the second floor of the Medical Arts Building, where Association business and library activities were carried on until 1935, when the first home for the central offices owned by the Association, a two-story brick residence at 1404 West El Paso Street, was secured.

Dr. Anderson reported in 1937 to the House of Delegates on the services available through the central office and its personnel. Membership by that time had mounted to 4,148, and the staff consisted of ten full time employees, one special service worker, and one part time clerk. The building housed offices of the secretary and assistant secretary; the bookkeeping and advertising department and archives; the office of the public relations counsel; the library reading room and stacks; and offices of the clerical staff. With pride the officers and trustees saw the number of books grow from 3,824 to 4,232; periodicals regularly received from 142 to 155; and reprints from 40,020 to 79,224 in four years. By 1940 the library had secured 120,612 reprints; 761 packages were circulated by mail; and in that year the first Committee on Library Endowment was appointed by the president, Dr. L. H. Reeves of Fort Worth.

Central office activities and services expanded again when medical preparation for war became important in 1942. The Committee on Procurement and Assignment of Physicians established itself in the Association office in Fort Worth to facilitate the distribution and utilization of the services of the medical profession. At that time 1,250 members of the Association were in uniform. Further extension of interests and activities of the Association and its central office came about in 1943 with the establishment of a Speakers Bureau and the Committee on Public Relations.

The next move of the central office took place in 1948 when the headquarters was transferred from Fort Worth to Austin, where the three story Victorian residence was leased at 700 Guadalupe Street. By this time membership had climbed to 5,770. The increase in the number of pages of the *Journal* (since the early 1900's the size of the *Journal* had tripled), the amount of advertising, the number of members, and the added services in the way of public relations activities, doctor placement, and mailings, plus aids to county societies and auxiliaries necessitated increased personnel and facilities throughout the years. These factors, as well as the recognition of the value of a permanent fireproof building to house the material and many irreplaceable records of the Association made the acquiring of a larger and permanent home for the Association desirable. After the move to Austin and before the next annual session, the Travis County Medical Society gave the Association the building site at Lamar Boulevard at Nineteenth Street and plans for the building and financing of the headquarters building were under way.

Especially crowded in the building at 700 Guadalupe was the library, which today has more than 22,000 bound and unbound items, with almost 400 periodicals being received regularly, a great increase from the items listed by the secretary in the transactions in 1908. Space for filing the 156,000 reprints at the Guadalupe Street location was limited; even by utilizing attic space in the residence, all the volumes could not be unpacked and made available for use. In the newly completed building on Lamar, all departments of the central office now have adequate facilities to take care of the many services offered to the more than 6,000 members of the Association, the more than 4,000 Auxiliary members, and the scores of persons not affiliated with either organization who request information.

The changing and widening scope of interest of the medical profession during the past one hundred years added considerably to the "growing pains" experienced by the central office. Mounting interest in medical economics, medical legislation, medical public relations, and medical education has been responsible for the creation of new activities by the Association and Auxiliary, necessitating the changes in residence of the central office through the years.

It is hoped the new building will provide sufficient space to carry on the medical profession's program for the next century of progress.

A PLEDGE FOR SERVICE

A permanent home for the Texas Medical Association is the fulfillment of long term planning by the medical leaders of Texas. It symbolizes the pledge of better service to Association members, to other doctors and related health personnel in Texas, to the Woman's Auxiliary, and—through all of these—better health for the people of the state.

In recent years because of the increased membership and expanded services which have made necessary more personnel, equipment, and records, the central office staff has been working under the distinct handicap of crowded space inconveniently arranged. In 1925 there were 3,403 members; the membership topped the 6,000 mark in 1950 and at the midyear in 1952 stood at 6,161, almost double that of a quarter of a century ago. The specially designed, spacious new headquarters building will permit the twenty-one Association employees and a representative of the State Advisory Committee to Selective Service to perform more effectively the services already established and will encourage the addition of new activities as they become desirable.

The doctor who is a good businessman likes to know where his dues dollars go. He wants to know "What's in the Association for me?" He is entitled to know what services are available and how he can get the most from them.

Not only the doctor and his wife have the right to ask help from the central office. The public, too, is served. Newspaper reporters needing biographical data on physicians, science students seeking material for term papers, even patients wanting to know if they will find a doctor or a hospital when they move to another town find answers from the Association headquarters.

Library

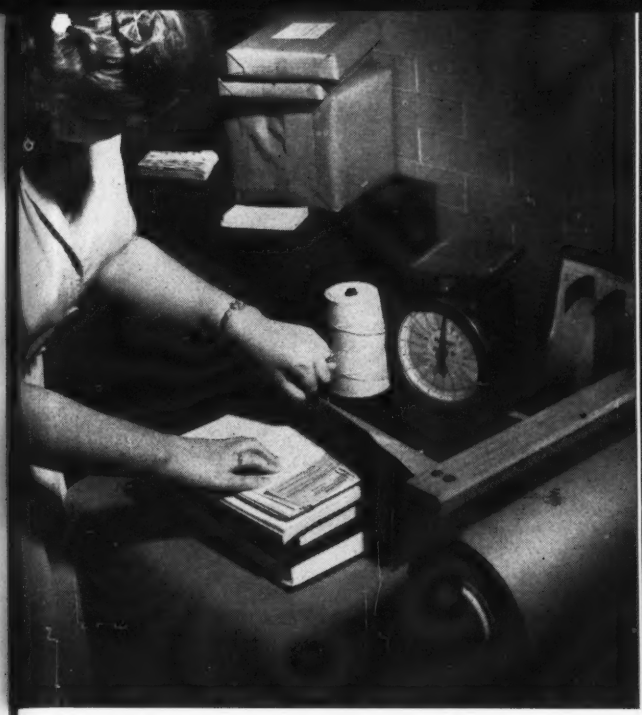
The library renders innumerable services to the doctors and to nonprofessional persons who are authorized to use its facilities. Its two main divisions are the package service library and the motion picture film library.

Included in the package service library are 372 periodicals which are received regularly, 6,921 books, and 156,000 reprints. If the physician requests information on specific medical subjects, a librarian compiles pertinent materials and mails a package to him for a two-week period. About 100 requests a month are filled by the package service method.

There are about 147 professional films and 46 films suitable for lay audiences available without charge to the medical profession or to lay groups. The average monthly requests for motion pictures total 85.

The library staff asks physicians to review new books for the *Journal,* and the book reviews, in return, encourage publishers to send more books to the library. The library

Several heads are better than one to plan the proposed statewide series of telephone broadcasts on postgraduate medical education. N. C. Forrester receives suggestions from Harriet Cunningham, Anna Keith, and Mrs. Katheryn Wendler.



A package of reference materials is made ready for mailing by Mrs. Mary Talley of the library staff.

Before sending out a motion picture film, Alliece Pigott rewinds the reel to view the film for possible damage.

also serves as a source of reference for all departments of the central office.

Members of the Auxiliary, in addition to other services from the library, may obtain on a loan basis program packets on socialized medicine and health education.

The library staff is composed of Mrs. Katheryn Wendler, assistant librarian, aided by Mrs. Mary Talley, Miss Alliece Pigott, and Miss Alice Walker.

Business Office

The business office is in charge of accounting for and making record of all monies received and spent for the entire organization, including a separate set of books for the funds of the Texas Memorial Medical Library Association. Membership cards are issued, individual permanent records kept up to date for each member, and annual reports of the county society secretaries checked against dues payments and copied for the permanent records. In the last three years the recording and forwarding of American Medical Association dues has doubled the amount of work necessary on membership records and more than doubled the amount of letter writing regarding dues.

The advertising and related correspondence for the *Texas State Journal of Medicine* is handled in this department. Layouts are made for the printer. The publisher's sworn statement on circulation of the *Journal* is made semiannually to the United States Government and national advertising services. A card index on advertisers from the first issue of the *Journal,* July, 1905, showing the amount of space they have used and for how long is kept.

Keeping the advertising standards of the *Journal* at a level to enable the doctor to take at face value any product advertised in its pages is accomplished through cooperating closely with the State Journal Advertising Bureau of the A. M. A. for out-of-state firms and with the county medical societies for local and state firms that wish to advertise in the *Journal* and for physicians who desire to use the classified advertising section.

Miss Anna Keith, the senior member in number of years of service with the central office force, is cashier and in charge of the business office; she is advertising manager of the *Journal* as well. Her assistants are Miss Mildred Whiteman, Mrs. Eula Lea Holmberg, and Miss Martha Lambert.

Journal, Public Relations, and Auxiliary Office

Editorial material for the *Texas State Journal of Medicine* and public relations and Woman's Auxiliary endeavors are closely related activities.

Exclusive of advertising, the editorial staff is responsible for everything that goes into the *Journal.* This big order includes obtaining competent opinion on scientific articles, editing those chosen for publication, proofreading, and handling correspondence with the authors. In addition departmental members write editorials and news articles and are responsible for the page make-up of the *Journal* other than its advertising.

Although any department of the central office is happy to help the Woman's Auxiliary, miscellaneous requests usually are channeled through the *Journal,* public relations, and Auxiliary office.

Projects initiated by the various committees and councils of the Association are promoted and publicized. The staff also helps with publicity for the Texas postgraduate assemblies and other activities sponsored by similar organizations. Kits have been prepared to help local societies develop telephone emergency and grievance committees. One staff member is responsible for writing "Health Talks," a series of articles on health and medicine sent to 485 weekly and 90 daily newspapers in Texas. Before being released to the newspapers each health talk is approved by a physician.

Miss Harriet Cunningham, the managing editor of the *Journal,* supervises public relations and Woman's Auxiliary work as well; she is assisted by Misses Ruth Trahan and Mary Stuart Warren, Mrs. Arleen Draker, and Mrs. Jean Clark. Daniel Lehman, who primarily devotes his time to the job of building superintendent, also assists with the production of publicity pieces.

Medical Services

The young woman who answers "Texas Medical Association" at telephone 7-9447, Austin, is Mrs. Elizabeth Wrights-

man. While at the switchboard she receives callers to the Association headquarters, announces them to the person they want to see, and directs them to their destination. She also assists with typing and with the clipping and sorting of newspaper articles for filing.

Recent graduates from medical schools and doctors moving to Texas frequently would like to know what towns in the state need physicians; conversely, communities needing doctors often rely on help from the Texas Medical Association. During the past nine months 62 physicians have been placed in areas needing medical care and 52 communities have been aided to secure doctors. At present about 150 physicians and 70 communities are on the active list of the physicians placement service of the Association.

Mrs. Wacille Johnson, who is in charge of this aspect of the Association work, also distributes electrical health transcriptions made by the American Medical Association to Texas radio stations. Already this year 84 series (each enabling a fifteen-minute program to be broadcast weekly for thirteen weeks) have been sent to 20 stations, with 6 new stations auditioning a series at present.

In charge of the vast files for the central office is Mrs. Betty Joyce Russell. Hers is the task of keeping up with the voluminous records which include reports of official bodies of the Association; data, including personnel forms, newspaper articles, and some photographs, on its members; information on national, regional, and state organizations related to medicine; and other more general correspondence and files.

Another duty of the file clerk is to receive and distribute the incoming mail for the entire office.

A tremendous job is the handling of outgoing mail. In addition to the Association's routine mail, special mailings large enough to enlist the aid of the entire central office staff are encountered occasionally. The Association has a postage meter and an addressing machine with a mailing list of members of the Association, advertisers in the *Journal,* and libraries and societies on a journal exchange basis—everyone to whom the *Journal* goes. In addition to the *Journal* mailing list of about 7,000 names (of which approximately 6,000 are members), there are those for the 4,000 members of the Woman's Auxiliary to the Texas Medical Association, its state officers, and county auxiliary presidents; county medical society presidents, secretaries, and public relations representatives; and daily and weekly newspapers in Texas. These lists are corrected and brought up to date at frequent intervals. The Association helps various medical groups in Texas, such as the medical schools, postgraduate medical assemblies, and tuberculosis and cancer associations, by addressing envelopes for them. During July, 1952, more than 59,000 pieces of mail were addressed by the mailing department.

Mimeographing is another valuable service of this department.

Don Gholston and Mr. Lehman operate the equipment in the mailing department. Claude Parham, caretaker for the new building, also assists with this work.

State Advisory Committee

Although officially separate from the Texas Medical Association, the headquarters for the State Advisory Committee to Selective Service are housed in the Association building. This committee advises the military services regarding the essentiality status of medical, dental, and veterinary reserve officers. It also makes recommendations as to the availability of special registrants and allied specialists subject to provisions of the doctor draft law.

Miss Jeanne Kerwin, an employee of this committee, keeps the files, carries on the stenographic work, and maintains liaison between members of the committee, the military branches, and the doctors affected by the doctor draft law. She works closely with the physicians placement service to assure adequate medical care for the smaller communities.

Special Services

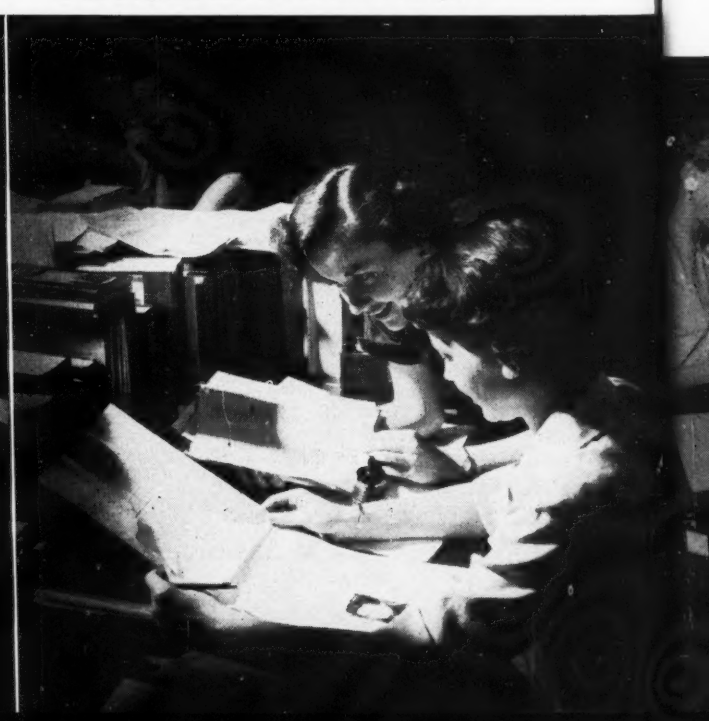
Through the central office the doctor can get help from a number of persons employed on a retainer or contract basis but not housed in the Association's building.

For example, Philip R. Overton, general counsel for the Association, can advise members, individual councils and committees of the Association, and other medical society officers regarding legal problems and current medical legislation.

A large number of Texas doctors have met Mr. Overton during his many trips throughout Texas to county society

A membership card is issued a newcomer of the Association by Mildred Whiteman (right) of the business office while Martha Lambert (left), a co-worker, checks his office record.

Mrs. Arleen Draker (right) confers with Mary Stuart Warren before releasing some Auxiliary news for publication in the *Journal.* In the background Ruth Trahan answers the telephone.



A Panhandle town is assured enough doctors as Jeanne Kerwin (left), representative of the State Advisory Committee to Selective Service, consults Mrs. Wacille Johnson, who heads the Association's physicans placement service, before recommending military service for a physician.

and other medical meetings and also in the same way the public relations counsel for the Association, W. E. Syers. A member of the Austin public relations firm of Syers, Pickle, and Winn, he helps county societies and other related medical groups in publicity and public relations matters. He and his associates are experts in radio, newspaper, and other types of public information media, have an art department, and can advise about the impact which specific activities will have on public opinion.

The payroll and audit of the central office bookkeeping records are in charge of an Austin accounting firm, Howard T. Cox. As the firm's representative, Henry V. Ramsey is one of the most popular men in Austin on payday, when he hands out checks to the twenty-one employees on the payroll of the Texas Medical Association.

Executive Secretary

The man responsible for coordinating the work of the departments of the central office, plus that of persons giving special services, is the executive secretary. He is probably the person with whom the individual doctor has the most frequent correspondence. N. C. Forrester, who holds this position, works under the direction of the Board of Trustees and in cooperation with the other officers of the Association.

The executive secretary, in addition to his official duties with the officers, councils, and committees of the Association, stands ready to help members with the problems which arise in their daily practice: those which involve relationships with their patients, their medical colleagues, the institutions in which they work, and the public.

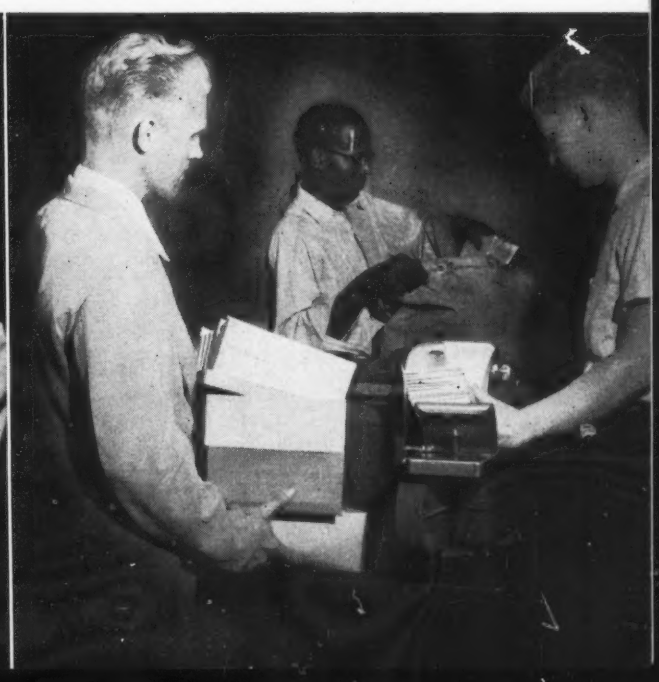
Correspondence is handled by Mr. Forrester with the help of his secretary, Miss Jeanie Lannom, and other members of the staff who may be in a position to render help on specialized problems. He frequently journeys to county, district, and other medical meetings throughout the state to learn directly of the problems confronting the medical profession and to explain what the central office staff can do to assist.

Among the duties of the executive secretary is his part in the planning of the Association's annual session, the semi-yearly Executive Council meetings, and other special committee and council meetings. Through his office the physical arrangements for these meetings are made, agendas prepared in advance, and minutes of the meetings taken for the permanent records of the Association.

Service to the individual member of the Association is the aim of the executive secretary and the entire staff of the central office. Whether it is accomplished through improvement of scientific meetings, a better library or state *Journal,* or extension of any other aid already in force, every effort of the Texas doctor's employees in his Austin headquarters is bent toward this important goal.

A newspaper deadline brings to the filing department a hurry-up call for biographical data on a Texas doctor. Jeanie Lannom (left) reads the request as Mrs. Elizabeth Wrightsman (center) examines the doctor's personnel file and Mrs. Jean Clark locates his photograph.

Into the postage meter go Health Talks for Texas newspapers, more than doubling the day's normal mailing load. Daniel Lehman (left) keeps the operator, Don Gholston, supplied with envelopes, while Claude Parham stuffs an already bulging mail sack.



FIFTY YEARS OF MEDICAL PROGRESS

Every aspect of man's life today reflects the remarkable progress made in science, invention, and culture. The medical profession, too, can point with pride to unbelievable progress in research and understanding, as well as the prevention, cure, and treatment of disease.

Medical science and the family doctor have managed during the past half century to add more than twenty years to man's life span, making it probable that a person will live to celebrate his sixty-seventh birthday in 1952, whereas in 1900 the average life span was 47.3 years.

The increased life span can be attributed to many advances in medicine—new drugs, improved techniques, better equipment, and intensive medical research. These advances are all reflected in the health record of America today. In 1900, of every 1,000 babies born, 150 did not reach their first birthday. Of the total deaths in that year one-fifth were infants. Today out of every 1,000 live births, about 30 infants die at or after birth.

At the same time, the babies' mothers have a better chance of survival in 1952. In 1933, the year in which the whole nation was included in the official registration for the first time, 6.2 mothers died for every 1,000 births. In 1947 this figure had been reduced to 1.3 for every 1,000 births, a reduction of 79 per cent in fourteen years. Two years later, the maternal mortality rate was 0.9 per 1,000 live births.

If a child did survive the childhood dangers with which he was threatened in 1900, he was faced by pneumonia, influenza, and tuberculosis in youth and adulthood. Pneumonia was the leading killer in the United States in 1900; of every 100,000 persons in the United States, 165 died of pneumonia or influenza complicated by pneumonia. In the same year the death rate of persons suffering with tuberculosis was 220 per 100,000 persons. Through improved methods of therapy, modern medicine has brought this rate to 30.2 per 100,000.

Medicine aided by better food, better housing, and better sanitation has managed to progress to the point that approximately one year of life has been added for every twenty months since 1940. Experiments in the field of geriatrics indicate that perhaps within thirty years the average man of 100 years will be as healthy as the man of 50 is today.

The United States at the beginning of 1950 had one doctor for every 750 persons, the highest record of any nation in the world with the exception of Palestine, where a temporarily high ratio exists because of an influx of refugee doctors.

The three biggest killers facing medicine today are heart disease, cancer, and apoplexy. Medical science is progressing daily in its search for knowledge about the causes and treatment of these killers, and some day may be able to reduce the danger of death from these causes as much as it has reduced mortality figures of tuberculosis, childbirth, and pneumonia. Although the incidence of the second deadliest disease, cancer, has increased, marked decreases have been recorded in tuberculosis, pneumonia, influenza, heart disease, diabetes, and the communicable diseases of childhood.

The fight against disease and premature death is being waged now with weapons which were largely unknown and undeveloped fifty years ago. The quest for better health, longer life, and improved medical care has come a long way in the past century and will continue in the next.

PRESERVING THE PAST

When the copper box in the cornerstone of the Texas Medical Association Memorial Library building is opened many years from now, persons examining the contents will obtain a fairly complete picture of medicine in Texas up to the mid-twentieth century. The items enclosed in the cornerstone when it was sealed in July included the following:

The 1951 revised Constitution and By-Laws of the Texas Medical Association and the revised 1942 Constitution and By-Laws of the Woman's Auxiliary to the Association.

A reprint of "Our Living Past Presidents," published in the January and February, 1949, issues of the *Texas State Journal of Medicine* with a historical chart of officers, annual session dates, and registration figures from 1853 to 1952.

A reprint of "The Story of Three Charters" from the May, 1951, *Journal* relating the historical background of the three charters of the Texas Medical Association since its beginning.

A July, 1905, copy of the *Texas State Journal of Medicine,* the first issue of the *Journal.*

Copies of the October, 1935, *Journal* containing a story and pictures of the move of the central office to the newly purchased residence at 1404 West El Paso Street in Fort Worth and the June, 1948, issue of the *Journal* containing transactions of the annual session at which the move of the central office from Fort Worth to Austin was decided upon.

A program of the eighty-fifth annual session of the Association in May, 1952, in Dallas; the thirty-fourth annual session program of the Woman's Auxiliary to the Association held in May, 1952, in Dallas; and the March and June, 1952, *Journals* containing the program and transactions of the eighty-fifth annual session.

An April 12, 1952, copy of *The Journal of the American Medical Association* containing the program of the 1952 A. M. A. annual session and pictures of the officers.

"Medical Story of Early Texas," by Dr. Pat Ireland Nixon, San Antonio physician and historian.

Copies of the April 29, 1951, Dallas *Daily Times Herald,* the January 25, 1949, San Antonio *Express,* and the May 4, 1952, Dallas *Morning News,* each with medical sections.

Catalogues and pictures of buildings and personnel at the University of Texas Medical Branch, Galveston; Baylor University College of Medicine, Houston; and the Southwestern Medical School of the University of Texas, Dallas.

Pictures of Drs. E. H. Cary, Dallas, only member of the Texas Medical Association who has served as President of the American Medical Association; F. J. L. Blasingame, Wharton, Association member now serving as a Trustee of the A. M. A.; and Sam N. Key, Austin, chairman of the Association's Building Committee for the Memorial Library.

A June, 1952, copy of the *Texas Dental Journal.*

A 1951 edition of "Policies, Regulations and Recommendations for the Accreditation of Professional Schools of Nursing of the Board of Nurse Examiners of the State of Texas."

Congratulatory letters from Allan Shivers, governor of Texas, and James P. Hart, chancellor of its University.

Letters to physicians of the future from Dr. Merton M. Minter, San Antonio, chairman of the Board of Trustees, and Dr. T. C. Terrell, Fort Worth, President of the Texas Medical Association.

A copy of the July 13, 1952, edition of the Austin *American-Statesman* containing reports of events in Texas at the time the cornerstone was sealed.

The 1952-1953 edition of the Texas Almanac.

"Texas History," by Eugene C. Barker, professor of American history at the University of Texas.

The Bible.

THEY MADE A DREAM COME TRUE

Although the new headquarters building of the Texas Medical Association is the work of many minds, hands, and hearts, the details have been the responsibility of a few.

Dr. Truman C. Terrell, Fort Worth, was chairman of the Board of Trustees which first received the mandate of the House of Delegates to erect a building; he has been succeeded by Dr. Merton M. Minter, San Antonio. Others who have served as Trustees during the period of planning and building the new structure are Drs. G. V. Brindley, Temple; E. A. Rowley, Amarillo; Robert W. Kimbro, Cleburne; F. J. L. Blasingame, Wharton; J. B. McKnight, San Angelo; and the late William M. Gambrell, Austin. Drs. Brindley, Gambrell, Allen T. Stewart of Lubbock, and Terrell have been Association presidents during the period, and Mesdames Joseph B. Foster, Houston; William M. Gambrell, Austin; Oscar W. Robinson, Paris; and Robert F. Thompson, El Paso, have been presidents of the Auxiliary.

Dr. Sam N. Key was named by the Trustees as chairman of the Building Committee with Drs. Gambrell, David Wade, and Charles P. Hardwicke, all of Austin, as members.

Another committee which has served a necessary function is the Building Finance Committee, consisting of Drs. L. C. Heare, Port Arthur, chairman; V. R. Hurst, Longview; Jay J. Johns, Taylor; J. C. Terrell, Stephenville; and S. D. Coleman, Navasota.

The firm of Staub and Rather of Houston was chosen as architects for the Texas Medical Association building, and the Yarbrough Construction Company of Austin was awarded the general contract for its construction. Mr. Fred Folmer, associate librarian of the University of Texas, Austin, was retained as consulting librarian.

During the past year N. C. Forrester, executive secretary of the Association, has been on the job twenty-four hours a day. His recent predecessors, Dr. Harold M. Williams and Tod Bates, also contributed to the project. A list of those who labored for an adequate building would be incomplete without mention of the late Dr. Holman Taylor, for many years secretary of the Association, and his assistant, the late Dr. R. B. Anderson, both of whom envisioned a greater Association and a more suitable building than they lived to see.

Recently the Trustees named a Committee on Building Celebration to plan appropriate ceremonies for dedication of the building. Dr. Gambrell was named chairman but later withdrew in favor of Dr. Brindley. Other members of the committee are Mrs. Robinson; Dr. Stewart; Dr. Kimbro; Dr. May Owen, Fort Worth; Dr. M. O. Rouse, Dallas; Dr. R. G. Baker, Fort Worth; and Dr. J. T. Billups, Houston.

The more than 6,000 physicians who are members of the Texas Medical Association and the more than 4,000 women who are members of the Auxiliary deserve credit for completion of the structure at 1801 Lamar Boulevard in Austin. Without their interest, financial support, and confidence, the medical profession of Texas could not have had the headquarters and library building from which service to the people of the state will emanate for scores of years.

First row: Dr. F. J. L. Blasingame, Dr. G. V. Brindley, Mrs. Joseph B. Foster, Mrs. William M. Gambrell, Dr. William M. Gambrell.
Second row: Dr. L. C. Heare, Dr. Sam N. Key, Dr. Robert W. Kimbro, Dr. J. B. McKnight, Dr. Merton M. Minter.
Third row: Mrs. O. W. Robinson, Dr. E. A. Rowley, Dr. Allen T. Stewart, Dr. T. C. Terrell, Mrs. Robert F. Thompson.

Austin, looking north from Sixth Street. The Capitol blocks Congress Avenue in the center, and the University tower is beyond and to the left. The Texas Medical Association building would be just off the picture to the left about midway between the Capitol and University.

HEADQUARTERS CITY

Primarily because of its central location and secondarily because it is the state capital, Austin has been chosen by more than 108 statewide associations as the site of their headquarters. Of these, several other than the Texas Medical Association relate directly to health, for example, the Texas Tuberculosis Association, Texas Division of the American Cancer Society, state office of the National Foundation for Infantile Paralysis, and Texas Society for Mental Health. Perhaps of less significance but of real meaning for association employees and for members who frequently have business with headquarters offices is the fact that Austin is a pleasant place in which to live and visit.

Austin was selected as the site for the capital of Texas in 1839. A group of five horsemen, sent by President Mirabeau B. Lamar specifically to find a suitable location for the headquarters of the young republic, chose the scenic spot on the Colorado River. Except for a brief period from 1842 to 1844, when a Mexican Army marching from San Antonio caused the government to be moved to Washington-on-the-Brazos, state administration has been housed in the Central Texas city ever since.

Like other groups devoted to the welfare of Texas citizens, medical men soon organized in the locale of the state government. On January 8, 1853, the doctors of Austin invited all authorized physicians of the state to attend a meeting. The group convened on January 17 and out of it developed the Texas Medical Association.

Epidemics of yellow fever and smallpox, and the consequent need for quarantine administration, resulted in the appointment of Dr. Robert Rutherford as the first State Health Officer in 1879. Thirty years later, the Legislature established the Texas State Board of Health. The sleek, white Health Department Building on Austin's East Fifth Street today houses a variety of medical services. Its laboratories, Bureau of Vital Statistics, and divisions for control of cancer, venereal disease, tuberculosis, and heart disease belong to all of Texas.

Other state agencies and institutions play a major role in Austin's medical picture. The Board for State Hospitals and Special Schools, the Basic Science Examining Board, and the State Board of Vocational Nurse Examiners have offices in the city, which is the site of the Austin State Hospital (for mental and nervous disorders), the Austin State School (for the mentally deficient), the Texas Schools for the Deaf and the Blind, and the Blind, Deaf, and Orphan School for Negroes.

As administrative home of The University of Texas, Austin is the heart of a vast program of health personnel training and scientific research. From his tower office, Chancellor James P. Hart coordinates the activities of the Medical Branch in Galveston, the M. D. Anderson Hospital for Cancer Research and the Postgraduate School of Medicine in Houston, and the Southwestern Medical School in Dallas, along with the many active University research units. The Hogg Foundation for Mental Hygiene also is quartered on the University campus.

Austin's three major hospitals are expanding to keep up with the city's fast-growing population. Additions to Brackenridge and Seton Hospitals will increase their combined capacities by 169 beds; St. David's is laying plans for a complete new building. The Air Force hospital at nearby Bergstrom Field provides 50 beds for military personnel.

Unusual scenic and recreational assets add to pleasant living in Austin. The grassy slopes and the cool, crystal waters of Barton Springs draw swimmers from April to November. Boating, fishing, and water sports are only fifteen minutes from the heart of downtown Austin. Beautiful Lake Austin, edged by rolling hills and sharp cliffs, curves for 20 miles northwest of the city.

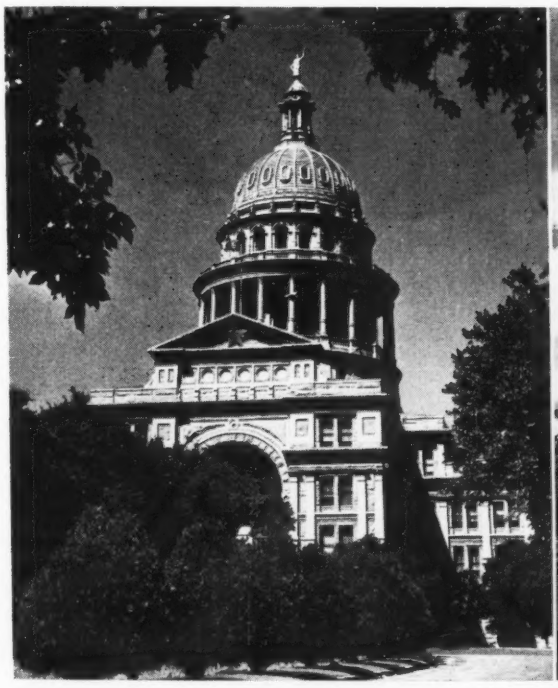
In addition to its recreation facilities, Lake Austin represents an important factor in Austin's invitation to industry. It is the sixth of a series of lakes and dams forming the Lower Colorado River Authority, which provides the area with an abundance of water and electricity. This water and power supply has helped to attract new business, thereby altering an economy which had previously been based on the University and State offices. Too, the library and technical staff of The University of Texas make invaluable aid accessible to commercial research laboratories. At present, food processing, building materials, furniture manufacturing, printing, and metal product fabrication are the leading industries; the fertile farmland south and east of Austin also makes an important agricultural contribution to the economy.

Perhaps the beauty of the rolling hills draws the kind of people who seek a gracious way of life, because Austin is a home of culture. Art-lovers flock to the home of renowned sculptress Elisabet Ney, and to Laguna Gloria, riverside mansion of Clara Driscoll Sevier, which are now the scenes of painting and sculpture exhibits. The Austin Symphony, Austin Community Concert Association, and the University's College of Fine Arts assure an impressive season of musical concerts. Drama is available year-round through the Austin Civic Theatre and the University. B. Iden Payne, the world's leading authority on Shakespeare and a member of the faculty, directs one Shakespearean classic every spring.

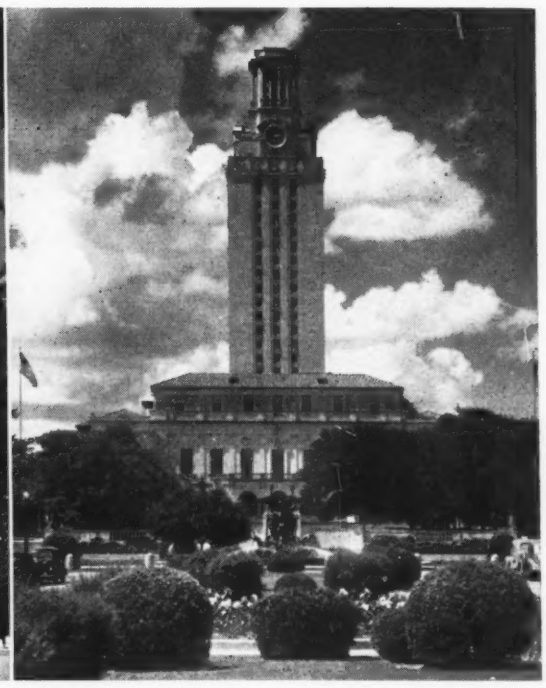
Museums which await the casual visitor or the student, include the Texas Memorial Museum and the United Daughters of the Confederacy and Daughters of the Republic of Texas museums. A little white house where William Sydney Porter lived is preserved in his memory as the O. Henry Home Museum. Another landmark of days gone by is the old French Embassy, a reminder of the Texas Republic.

Austin is the only city that can be found with the "tower" lighting system shedding a misty blue glow over the area at night. The towers are iron frames 150 feet high, crowned with six mercury vapor lamps. Twenty-seven of the original thirty-two towers still stand, joining with the Capitol dome and the tower of The University's Main Building to give Austin a unique skyline.

Most people who spend a little time in Austin want to come back. Many decide to make it their permanent residence. And just as individuals find it a good place to live, so do associations find it a satisfying home.



South entrance and dome of the Capitol of the State of Texas. The wing on the right contains the Senate; the House of Representatives is in a similar wing hidden behind the trees at the left.



Main approach to the Administration Building and Mirabeau B. Lamar Library of The University of Texas. The Littlefield Fountain and a shaded mall lead to the massive Main Building with its twenty-seven-story tower.

ORGANIZED FOR ACTION

The Texas Medical Association is an organization of many interests and therefore must have a fairly complex structure to assure proper coverage of each phase of activity.

The declared purpose of the Association is "to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members, and to protect them against imposition; and to enlighten and direct public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life."

White physicians holding the degree of doctor of medicine and legally registered to practice medicine in Texas who do not practice sectarian medicine and who subscribe to the Principles of Medical Ethics of the American Medical Association are eligible for membership, as are white medical officers of the federal government and teachers in class A medical schools who are not required to register under the Medical Practice Act and who are residents of Texas.

Chartered by the State of Texas and operating under a Constitution and By-Laws, the Texas Medical Association is governed by a House of Delegates made up of representatives from county medical societies affiliated with the state organization and of officials who hold ex-officio membership in the House.

A Board of Trustees supervises the activities of the central office and manages the financial affairs of the Association. A Board of Councilors, representing fifteen geographical districts, deals with county and district medical societies and with questions of medical ethics. Councils having members with overlapping terms of office work in areas of broad and general concern, on the whole, while committees—some of them "standing" and also with overlapping membership terms and some of them "special" with only yearly tenure—deal with more specific problems. Special delegates represent the Texas Medical Association to related groups.

The Texas Medical Association stands midway between the county medical society and the American Medical Association, bringing the immediate, personal, and localized problems of the physicians of a small area to the attention of the national organization and calling to the attention of these same physicians the varied services of the A. M. A. and the forces and trends which affect medicine and health nationwide. The state organization is more than a go-between, of course, for it is in a position to perform many services and achieve many worthy objectives which it would be inappropriate or impossible for either the county or the national groups to attempt.

At each level of organization, the medical profession has an important adjunct in the form of a woman's auxiliary, which has a program of education, philanthropy, and community service extending the aims of the Association.

The table below suggests the complexity of the Texas Medical Association, showing that all of its activities stem from the democratic processes of the House of Delegates and naming the numerous officers, boards, councils, and committees which labor year-round for the betterment of health in Texas. The central office, although under the immediate supervision of the Board of Trustees, is at the beck and call of every official, committee chairman, or "garden variety" member of the Association, and helps the entire organization to promote better health for all Texans.

HOUSE OF DELEGATES

Officers
President
President-Elect
Vice-President
Secretary
Treasurer
Speaker of House of Delegates
Vice-Speaker of House of Delegates

Board of Trustees
Committee to Write History of Texas Medical Association
Building Committee
Building Celebration Committee

Board of Councilors

Delegates to American Medical Association

Councils
Executive Council
Medical Defense
Medical Jurisprudence
Scientific Work
Medical Economics
Medical Education and Hospitals
War Council

Central Office
Executive Secretary
Library
Journal
Business
Physician Placement
Public Relations
Woman's Auxiliary
Other Services

State Advisory Committee for Selective Service

Standing Committees
Cancer
Medical History
Public Relations
Tuberculosis
Library Endowment
Mental Health
Public Health

Special Committees
Arrangements for Annual Session
Memorial Exercises
Scientific Exhibits
Texas Society of Medical Technologists
Rural Health
Revision of Constitution and By-Laws
Nursing Care
Negro Medical Facilities
Study of Alcoholism
National Emergency Medical Service
Blood Banks
Texas Chapters of Student A. M. A.
Liaison with Texas Bar Association
Doctor Distribution

Special Delegates
Texas Hospital Association
State Health Education Council
Texas State Nutrition Council
State Rural Health Council
Lone Star State Medical Association
Louisiana State Medical Association
Arkansas Medical Society
Texas State Dental Society
New Mexico Medical Society
Texas Polio Planning Committee

BETTER HEALTH FOR TEXAS

ACKNOWLEDGMENTS

Drs. Pat I. Nixon of San Antonio and L. H. Reeves of Fort Worth, Miss Hope Chase of Fort Worth, the Fort Worth Public Library, the Fort Worth National Bank, and the Continental National Bank of Fort Worth provided information and pictures relative to the history of the Texas Medical Association.

George Seagert of the Austin Chamber of Commerce contributed information about and photographs of Austin.

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